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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515) 281-3355 or (515) 242-6873

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Replace Analysis
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Remove Chapter 11
Replace Reserved Chapter 12 with Reserved Chapters 11 and 12
Replace Chapter 16
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Replace Chapters 400 to 402
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Replace Reserved Chapters 405 to 499 with Reserved Chapters 404 to 499

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The Index will not be updated until further notice.

AGING, DEPARTMENT ON[17]

Prior to 5/20/87, see Commission on the Aging[20]
Delay: Effective date (June 24, 1987) of Chapters 1 to 18 delayed 70 days pursuant to Iowa Code section 17A.4(5) by the Administrative Rules Review Committee at their June 9, 1987, meeting.
[Prior to 1/27/10, see Elder Affairs Department[321]]

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[Prior to 5/20/87, see Aging, Commission on the[20] rules 4.2 and 9.6]
[Prior to 1/27/10, see Elder Affairs Department[321] Ch 8]

17—8.1(231) Purpose. This chapter establishes procedures for notice and appeal of penalties imposed for interference with the official duties of a long-term care resident's advocate/ombudsman, which are established in 2010 Iowa Acts, Senate File 2263, section 7, and in accordance with Section 712 of the federal Older Americans Act, as codified at 42 U.S.C. Section 3058g. This chapter also establishes criteria for serving under the volunteer long-term care ombudsman program. The resident's advocates/ombudsmen investigate complaints related to the actions or inactions of long-term care providers that may adversely affect the health, safety, welfare, or rights of residents and tenants who reside in long-term care facilities, assisted living programs, and elder group homes.
[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.2(231) Definitions.

"Access" means the term defined in 2010 Iowa Acts, Senate File 2263, section 7.

"Assisted living program" means a program defined in Iowa Code section 231C.2 and certified under Iowa Code chapter 231C.

"Civil penalty" means a civil money penalty not to exceed the amount authorized under 2010 Iowa Acts, Senate File 2263, section 7.

"Department" means the Iowa department on aging.

"Director" means the director of the department on aging.

"Elder group home" means a home defined in Iowa Code section 231B.1 and certified under Iowa Code chapter 231B.

"Long-term care facility" means a long-term care unit of a hospital or a facility licensed under Iowa Code section 135C.1 whether the facility is public or private.

"Long-term care resident's advocate/ombudsman" means the individual employed to carry out the duties of 2010 Iowa Acts, Senate File 2263, section 7.

"Office of the state long-term care resident's advocate" means the office established in 2010 Iowa Acts, Senate File 2263, section 7.

"Official duties" means those duties specified in 2010 Iowa Acts, Senate File 2263, section 7, and in the federal Older Americans Act.

"Volunteer long-term care ombudsman" means a volunteer who has successfully completed all requirements and received certification from a long-term care resident's advocate/ombudsman.
[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.3(231) Interference. A local long-term care resident's advocate/ombudsman or trained volunteer long-term care ombudsman certified under rule 17—8.7(231) who is denied access to a resident or tenant in a long-term care facility, assisted living program, or elder group home, or to medical and personal records while in the course of conducting official duties or whose work is interfered with during the course of an investigation shall report such denial or interference to the office of the state long-term care resident's advocate who will report the interference to the director of the department on aging.
[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.4(231) Monetary civil penalties—basis. The director, in consultation with the state long-term care resident's advocate/ombudsman, may impose a monetary civil penalty of $1,500 on an officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who intentionally prevents, interferes with, or attempts to impede the duties of the state or a local long-term care resident's advocate/ombudsman. If the director imposes a penalty for a violation under this rule, no other state agency shall impose a penalty for the same interference violation.
[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.5(231) Monetary civil penalties—notice of penalty. The department on aging shall notify the officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home in writing by certified mail of the intent to impose a civil penalty. The notice shall include, at a minimum, the following information:

1. The nature of the interference and the date the action occurred.
2. The statutory basis for the penalty.
3. The amount of the penalty.
4. The date the penalty is due.
5. Instructions for responding to the notice, including information on the individual's right to appeal.

[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.6(231) Monetary civil penalties—appeals. An officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who is assessed a monetary civil penalty for interference with the official duties of a long-term care resident's advocate/ombudsman may appeal the penalty by informing the department of the intent to appeal in writing within ten days after receiving a notice of penalty. Appeals shall follow the procedures set forth in 17—Chapter 13.

[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

17—8.7(231) Volunteer long-term care ombudsman program.

8.7(1) Application. Any individual may apply to the resident's advocate/ombudsman program to become a volunteer long-term care ombudsman. A resident advocate committee member shall be given priority in the selection process and may become a certified volunteer long-term care ombudsman pending successful completion of the required training and background checks.

a. Application forms. Application forms may be obtained from the resident's advocate/ombudsman program at the department on aging address listed in rule 17—2.1(231) or from other organizations designated by the department.

b. Submission of forms. Each applicant shall complete an application and submit it to the department address listed in rule 17—2.1(231).

8.7(2) Conflict of interest.

a. Prior to certification, applicants for the volunteer long-term care ombudsman program must not have a conflict of interest or have had a conflict of interest within the past two years in accordance with the Older Americans Act. A conflict of interest shall be defined as:

(1) Employment of the applicant or a member of the applicant's immediate family within the previous year by a long-term care facility or by the owner or operator of any long-term care facility;

(2) Current participation in the management of a long-term care facility by the applicant or a member of the applicant's immediate family;

(3) Current ownership or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility or long-term care service by the applicant or a member of the applicant's immediate family;

(4) Current involvement in the licensing or certification of a long-term care facility or provision of a long-term care service by the applicant or a member of the applicant's immediate family;

(5) Receipt of remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility by the applicant or a member of the applicant's immediate family;

(6) Acceptance of any gifts or gratuities from a long-term care facility or a resident or a resident's representative;

(7) Acceptance of money or any other consideration from anyone other than the office of the state long-term care resident's advocate/ombudsman for the performance of an act in the regular course of long-term care;

(8) Provision of services while employed in a position with duties that conflict with the duties of a volunteer long-term care ombudsman;

(9) Provision of services to residents of a facility in which a member of the applicant's immediate family resides; or

(10) Participation in activities which negatively affect the applicant's ability to serve residents or which are likely to create a perception that the applicant's primary interest is other than as an advocate for the residents.

b. Immediate family shall be defined as father, mother, son, daughter, brother, sister, aunt, uncle, first cousin, nephew, niece, wife, husband, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepbrother, stepchild, stepsister, half sister, half brother, grandparent or grandchild.

8.7(3) Applicants shall not be accepted into the program if:

a. It is determined that the applicant has a conflict of interest as listed in subrule 8.7(2); or

b. The applicant has unfavorable references, which shall include a DCI criminal background check and abuse check;

c. The applicant lives in any part of a continuing care retirement community, or any housing owned by the long-term care facility in which the volunteer would function.

8.7(4) Training. Prior to certification, applicants must successfully complete the required training as approved by the resident's advocate/ombudsman. Successful completion shall be defined as completion of all assignments and tasks during training, demonstration of proper techniques and skills, and an understanding of the role of the volunteer long-term care ombudsman in the long-term care setting. The applicant shall complete a minimum of 24 hours of approved training, which shall include, but not be limited to:

a. History and overview of resident's advocate/ombudsman program;

b. Terminology;

c. Resident rights;

d. State and federal law, rules and regulations regarding long-term care facilities;

e. Regulatory process in long-term care facilities;

f. Aging process, common medical conditions and terminology;

g. Life in a long-term care facility and culture change;

h. Communication skills;

i. Confidentiality;

j. Problem solving and documentation, and follow-up of complaints;

k. Dynamics of abuse and neglect;

l. Ethics; and

m. Resources for volunteer long-term care ombudsmen.

8.7(5) Approval for certification. Final approval for certification as a volunteer long-term care ombudsman shall be made by the resident's advocate/ombudsman and shall be subject to the applicant's successful completion of the required training and to a favorable report from the instructor. The resident's advocate/ombudsman has the right to require that the applicant receive additional personal training prior to certification and has the right to deny certification to applicants not meeting the above training criteria.

8.7(6) Certification.

a. Notification. A volunteer long-term care ombudsman shall be notified in writing within 14 days following the conclusion of the training program if certification has been continued or revoked.

b. Certification shall initially be for one year, with recertification available following the volunteer's completion of a minimum of ten hours of approved continuing education in the first year and completion of a progress review by the residents of the facility, the facility administrator and staff, and the resident's advocate/ombudsman or a representative from the office of the state long-term care resident's advocate/ombudsman program.

c. After the volunteer's successful completion of one year as a volunteer long-term care ombudsman, the resident's advocate/ombudsman may recertify the volunteer for a two-year period.

8.7(7) Continuing education.

a. All certified volunteer long-term care ombudsmen shall complete a minimum of ten hours of continuing education the first year and a minimum of six hours of continuing education each year thereafter. Continuing education may include, but is not limited to:

(1) Scheduled telephone conference calls with representatives from the office of the state long-term care resident's advocate/ombudsman program;

(2) Governor's conference on aging;

(3) Area Alzheimer's disease conferences;

(4) Elder abuse conferences;

(5) Courses related to aging conducted by a local community college or university or via the Internet;

(6) Other events as approved in advance by the resident's advocate/ombudsman.

b. Volunteer long-term care ombudsmen are responsible for reporting continuing education hours to the resident's advocate/ombudsman or designee within 30 days following the completion of the continuing education event.

8.7(8) Contesting an appointment. A provider who wishes to contest the appointment of a volunteer shall do so in writing to the resident's advocate/ombudsman. The final determination shall be made by the resident's advocate/ombudsman within 30 days after receipt of notification from the provider.

8.7(9) Certification revocation.

a. Reasons for revocation. A volunteer long-term care ombudsman's certification may be revoked by the resident's advocate/ombudsman for any of the following reasons: falsification of information on the application, breach of confidentiality, acting as a volunteer long-term care ombudsman without proper certification, attending less than the required continuing education training, voluntary termination, unprofessional conduct, failure to carry out the duties as assigned, or actions which are found by the resident's advocate/ombudsman to violate the rules or intent of the program.

b. Notice of revocation. The resident's advocate/ombudsman shall notify the volunteer and the facility in writing of a revocation of certification.

c. Request for reconsideration. A request for reconsideration or reinstatement of certification may be made in writing to the resident's advocate/ombudsman. The request must be filed within 14 days after receipt of the notice of revocation.

d. Response time. The resident's advocate/ombudsman shall investigate and consider the request and notify the requesting party and the facility of the decision within 30 days of receipt of the written request.

8.7(10) Access.

a. Visits to facilities. A volunteer long-term care ombudsman may enter any long-term care facility without prior notice. After notifying the person in charge of the facility of the volunteer long-term care ombudsman's presence, the volunteer long-term care ombudsman may communicate privately and without restriction with any resident who consents to the communication.

b. Visits to resident's living area. The volunteer long-term care ombudsman shall not observe the private living area of any resident who objects to the observation.

c. Restrictions on visits. The facility staff member in charge may refuse or terminate a volunteer long-term care ombudsman visit with a resident only when written documentation is provided to the volunteer long-term care ombudsman that the visits are a threat to the health and safety of the resident. The restriction shall be ordered by the resident's physician, and the order shall be documented in the resident's medical record.

8.7(11) Duties. The volunteer long-term care ombudsman shall assist the resident's advocate/ombudsman or designee in carrying out the duties described in the Older Americans Act. Primary responsibilities of a volunteer long-term care ombudsman shall include:

a. Conducting initial inquiries regarding complaints registered with the long-term care resident's advocate/ombudsman;

b. At the request of the resident's advocate/ombudsman or designee, providing follow-up visits on cases investigated by the resident's advocate/ombudsman or designee;

c. Attending, assisting with, or providing technical assistance to resident and family council meetings as needed;

d. At the request of the resident's advocate/ombudsman or designee, making follow-up visits to a facility after a department of inspections and appeals survey or complaint investigation to monitor the progress and changes listed in the plan of correction or to monitor the correction of deficiencies;

e. Tracking, monitoring and following up on publicly available information regarding facility performance;

f. Identifying concerns in a facility. Concerns identified should be discussed with the chair of the resident advocate committee to determine an appropriate course of action to reach resolution;

g. Completing all reports and submitting them to the resident's advocate/ombudsman in a timely manner; and

h. Completing exit interviews when the volunteer ombudsman resigns.

[**ARC 8489B**, IAB 1/27/10, effective 1/7/10; **ARC 8939B**, IAB 7/14/10, effective 7/1/10]

These rules are intended to implement 2010 Iowa Acts, Senate File 2263, section 7.

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[Filed emergency 12/17/82—published 1/5/83, effective 12/29/82]
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[Filed emergency 8/20/87—published 9/9/87, effective 9/2/87]
[Filed 1/16/04, Notice 10/29/03—published 2/4/04, effective 3/10/04]
[Filed Emergency ARC 8489B, IAB 1/27/10, effective 1/7/10]
[Filed Emergency After Notice ARC 8939B (Notice ARC 8772B, IAB 5/19/10), IAB 7/14/10, effective 7/1/10]

1 Effective date of subrule 20—4.2(1) delayed 70 days by the Administrative Rules Review Committee. (IAB 12/22/82). Delay lifted by Committee on January 4, 1983.

2 Effective date of Ch 8 delayed 70 days by the Administrative Rules Review Committee.

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[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the "umbrella" of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

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[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
SALES PRACTICES

191—15.1(507B) Purpose. This chapter is intended to establish certain minimum standards and guidelines of conduct by identifying unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as prohibited by Iowa Code chapter 507B.

191—15.2(507B) Definitions.

"Advertisement" for the purpose of these rules shall be material designed to create public interest in insurance or an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

1. Printed and published material, audio and visual material, and descriptive literature of an insurer or producer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, computer on-line networks and similar displays; descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and sales talks, presentations, and material for use by producers.

2. However, for the purpose of these rules "advertisement" shall not include: communications or materials used within an insurer's own organization and not intended for dissemination to the public; communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy; and a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

"Aftermarket crash parts" means replacement parts as defined in Iowa Code section 537B.4.

"Certificate" means a statement of the coverage and provisions of a policy of group accident and sickness insurance which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

"Duplicate Medicare supplement insurance" shall mean the sale or the attempt to knowingly sell to an individual a policy of insurance designed to supplement Medicare benefits as provided in The Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965 as then constituted or later amended when the individual is already insured under such a policy.

"Duplication" means policies of the same coverage type according to minimum standards classifications outlined in 191 IAC 36.6(514D) which overlap to the extent that a reasonable individual would not consider the ownership of the policies to be beneficial.

"Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

"Illustrated scale" shall mean a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale as defined in 191 IAC 14.4(507B).

"Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

"Insurer" shall mean any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the business of insurance.

"Invitation to contract" means an advertisement for accident and sickness insurance that is neither an invitation to inquire nor an institutional advertisement.

"Invitation to inquire" means an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss

for which benefits are payable. An invitation to inquire may not refer to cost but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.

"Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

"Limited benefit health coverage" shall have the same meaning as defined in 191—subrule 36.6(10).

"Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers and adjusters. "Person" shall also mean any corporation operating under the provisions of Iowa Code chapter 514 and any benevolent association as defined and operated under Iowa Code chapter 512A. For purposes of this chapter, corporations operating under the provisions of Iowa Code chapter 514 and Iowa Code chapter 512A shall be deemed to be engaged in the business of insurance.

"Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for insurance benefits.

"Preneed funeral contract or prearrangement" shall mean an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

"Producer" shall mean a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located or to be performed in this state.

"Prominently" or *"conspicuously"* means that the information to be disclosed will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

"Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

"Twisting" shall mean any action by a producer or insurer to induce or attempt to induce any individual to lapse, forfeit, surrender, terminate, retain, assign, borrow, or convert a policy or an annuity in order that such individual procure another policy or annuity, when such action would operate to the overall detriment of the interests of the individual.

191—15.3(507B) Advertising.

15.3(1) *Form and content of advertisements.* The format and content of an advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to misrepresent or deceive. Whether an advertisement has a capacity or tendency to misrepresent or deceive shall be determined by the overall impression that the advertisement may be reasonably expected to create upon an individual in the segment of the public to which it is primarily directed and who has average education, intelligence and familiarity with insurance terminology for products in that market.

Information regarding exceptions, limitations, reductions and other restrictions required to be disclosed by this rule shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

15.3(2) *Prohibited terms and disclosure requirements for health insurance.*

a. No advertisement shall contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

b. No advertisement shall contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free," "extra cash" and substantially similar

phrases which have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable an individual to make a profit from being hospitalized.

d. No advertisement shall use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

e. An advertisement which refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

f. An advertisement may contain a brief description of coverage in an invitation to inquire so long as it is limited to a brief description of the loss for which benefits are payable. The brief description may also contain the dollar amount of benefits payable or the period of time during which benefits are payable, or both, but may not refer to the cost of the policy.

g. An advertisement for a policy which contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss shall prominently disclose the existence of such periods.

h. An invitation to inquire shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

15.3(3) *Prohibited terms in life insurance and annuity policies.* No advertisement for a life insurance or annuity policy shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "retirement plan," or other similar term which has the capacity or tendency to mislead an insured or prospective insured to believe that the insurer is offering something other than an insurance policy or some benefit not available to other individuals of the same class and equal expectation of life. An advertisement shall not state that there are "no more premiums" or that premiums will "vanish" or "disappear" or use similar terms when such statement is not based on the guaranteed rates.

15.3(4) *Exclusions, limitations, exceptions and reductions.* Words and phrases used in an advertisement to describe policy exclusions, limitations, exceptions and reductions shall clearly, prominently and accurately indicate the negative or limited nature of the exclusions, limitations, exceptions and reductions.

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or other policies providing benefits that are limited in nature shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS POLICY PROVIDES LIMITED BENEFITS," or "THIS IS A CANCER-ONLY POLICY."

15.3(5) *Use of statistics.* An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

15.3(6) *Introductory, initial or special offers.*

a. An advertisement shall not directly or by implication represent that a policy is an introductory, initial or special offer, or that a person will receive advantages not available at a later date, or that the offer is available only to a specified group of persons, unless such is the fact.

b. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in each portion of the advertisement where the initial reduced premium appears. This paragraph shall not apply to annual renewable term policies.

15.3(7) *Testimonials or endorsements by third parties.*

a. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules.

b. If the person making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements constitutes compensation and requires disclosure. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

c. An advertisement which states or implies that an insurer or an insurance product has been approved or endorsed by any person or other organizations must also disclose any proprietary or other relationship between the parties.

15.3(8) *Disparaging and incomplete comparisons and statements.* An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage other insurers, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of an insurer in the insurance business.

15.3(9) *Identity of insurer.*

a. The name of the actual insurer shall be clearly identified in all advertisements for a particular policy. An advertisement shall not use a trade name, insurance group designation, name of a parent company, name of a particular company division, service mark, slogan, symbol or other device which would have the capacity and tendency to misrepresent the true identity of an insurer.

b. No advertisement shall use any combination of words, symbols, or physical materials which by its content, phraseology, shape, color or other characteristics is so similar to combinations of words, symbols, or physical materials used by a municipal, state or federal agency that it would lead a reasonable individual to believe that the advertisement is approved, endorsed or accredited by an agency of the municipal, state, or federal government.

15.3(10) *Disclosure requirements for life insurance and annuities.*

a. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

b. An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

c. Dividends.

(1) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends for an annuity are illustrated, the illustration must be based on the insurer's illustrated scale and must contain a statement that the illustration is not to be construed as a guarantee or estimate of dividends to be paid in the future.

(2) An advertisement shall not state or imply that the illustrated scale under a participating policy or pure endowments will be or can be sufficient at any future time to ensure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

d. An advertisement of a deferred annuity shall not state the net premium accumulation interest rate unless it discloses in close proximity thereto and with equal prominence the actual relationship between the gross and net premiums.

e. An advertisement that states the projected values of a policy must use the guaranteed interest rates in determining such projected values and, in addition, may show other projected values based on interest rates which comply with the illustrated scale. Any statements containing or based upon an interest rate higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable statements containing or based upon the guaranteed accumulation interest rates. If the policy does not contain a provision for a guaranteed interest rate, any advertisement showing projected values must clearly state that the rates are not guaranteed. This subrule does not apply to an illustration or supplemental illustration subject to the provisions of the Life Illustrations Model Regulation, 191 IAC 14.

f. An advertisement or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such advertisement may be used for the purpose of demonstrating the cash flow pattern of a policy if such advertisement is accompanied by a statement disclosing that the advertisement does not recognize that, because of interest, a dollar in the future may not have the same value as a dollar at the time of the presentation.

g. An advertisement of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are also shown separately in close proximity thereto.

h. A statement regarding the use of life insurance cost indexes shall include an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

i. A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the insurer's illustrated scale and is not guaranteed.

15.3(11) *Special offers.* Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had the recipient's eligibility for the insurance individually determined in advance when the advertisement is directed to all individuals in a group or to all individuals whose names appear on a mailing list.

15.3(12) *Disclosure requirement.* In an advertisement that is an invitation to contract for an accident and sickness insurance policy that is guaranteed renewable, cancelable or renewable at the option of the company, the advertisement shall disclose that the insurer has the right to increase premium rates if the policy so provides.

15.3(13) *Group or quasi-group implications.*

a. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and, as members, enjoy special rates or underwriting privileges, unless that is the fact.

b. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their class membership entitles the member to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

c. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

d. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct application required need not be on a separate document or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly,

the use of terms such as "enroll" or "join" to imply group or blanket insurance coverage is prohibited when that is not the fact.

e. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

15.3(14) *Compliance with Medicare supplement advertising rules.* Insurers and producers shall comply with the Medicare supplement advertising rules set forth in 191—Chapter 37, Division II.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—15.4(507B) Life insurance cost and benefit disclosure requirements.

15.4(1) The definition of terms applicable to this rule and its appendices will be found in Appendix I.

15.4(2) Except as hereafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any insurer issuing life insurance contracts including fraternal benefit societies.

Unless otherwise specifically included, this rule shall not apply to:

a. Annuities.

b. Credit life insurance.

c. Group life insurance, except for disclosures relating to preneed funeral contracts or prearrangements as provided herein. These disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy.

d. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

e. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

15.4(3) Prior to or at delivery of a life insurance policy, an insurer or producer shall provide the prospective purchaser the following:

a. A life insurance buyer's guide in the current form prescribed by the National Association of Insurance Commissioners or language approved by the commissioner of insurance, and

b. A policy summary as defined in Appendix I.

15.4(4) A policy summary is not required to include information available in the policy form or illustration. If an illustration subject to the provisions of 191 IAC 14, Life Insurance Illustrations Model Regulation, is used in the sale of a policy, delivery of a policy summary is not required. A policy summary may not include any element that is not guaranteed.

191—15.5(507B) Health insurance sales to individuals 65 years of age or older. The sale of duplicate Medicare supplement insurance is prohibited.

191—15.6(507B) Preneed funeral contracts or prearrangements.

15.6(1) *Advertising.* An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

a. The fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, and

b. The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

15.6(2) *Application.* Prior to accepting an application, initial premium or deposit, an insurer or producer must adequately disclose:

a. The relationship of the life insurance policy or annuity contract to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

b. The impact on the prearrangement of any:

(1) Changes in the life insurance policy or annuity contract including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds,

(2) Penalties to be incurred by the policyholder as a result of failure to make premium payments,

(3) Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

c. A list of the merchandise and services which are supplied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

d. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the prearrangement;

e. Any penalties or restrictions including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

f. The fact that a sales commission or other form of compensation is being paid and, if so, the identity of the person to whom it is paid.

191—15.7(507B) Twisting prohibited. No insurer or producer shall engage in the act of twisting.

191—15.8(507B) Producer responsibilities.

15.8(1) *Required disclosures.* A producer shall inform the prospective purchaser, prior to commencing an insurance sales presentation, that the producer is acting as an insurance producer and inform the prospective purchaser of the producer's full name and the full name of the insurance company which the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify its full name to a prospective purchaser.

15.8(2) *Improper sales tactics.*

a. Producers and insurers shall not employ any method of marketing or tactic which uses undue pressure, force, fright, threat, whether explicit or implied, to solicit the purchase of insurance.

b. A producer shall not:

(1) Execute a transaction for an insurance customer without authorization by the customer to do so; or

(2) Commit any act which shows that the producer has exerted undue influence over a person.

c. Producers and insurers shall not, without good cause:

(1) Fail or refuse to furnish any individual, upon reasonable request, information to which that individual is entitled, or to respond to a formal written request or complaint from any individual.

(2) Sell an insurance policy or rider to an individual which is a duplication of a policy or rider which the individual owns or for which the individual has applied at the time of the sale.

15.8(3) *Prohibited designations and fees.*

a. When an insurance producer is engaged only in the sale of insurance policies or annuities, the insurance producer shall not hold the producer out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist solely engaged in the business of financial planning or giving advice relating to investments, insurance, real estate, tax matters or trust and estate matters. This provision does not preclude insurance producers who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance.

b. An insurance producer shall not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement required by paragraph *"c"* or to the solicitation of the sale of a product or service that the producer is also an insurance producer and that a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including the disclosure in any disclosure required by federal or state securities law.

c. An insurance producer shall not charge fees other than commissions unless such fees are based upon a written agreement signed by the client in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the client at the time the agreement is signed by the client. The agreement must specifically state:

(1) The service for which the fee is to be charged;

(2) The amount of the fee to be charged or how it will be determined or calculated; and

(3) That the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

d. Producers shall not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. This prohibition shall not apply to assigned risk policies and commercial property and casualty policies. Any additional fee that a producer intends to charge for assigned risk policies and commercial property and casualty policies must be fully disclosed to the insured.

e. Producers shall comply with rule 191—10.19(522B) in using senior-specific certifications and professional designations in the sale of life insurance and annuities.

15.8(4) *Suitability.* A producer shall not recommend to any person the purchase, sale or exchange of any life insurance policy, or any rider, endorsement or amendment thereto, without reasonable grounds to believe that the transaction or recommendation is not unsuitable for the person based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information known by the producer. For purposes of this subrule, when a producer recommends a group life insurance policy, "person" shall refer to the intended group policyowner.

15.8(5) *Prohibited acts.*

a. For purposes of this subrule:

"Gift" means a rendering of anything of value in return for which legal consideration of equal or greater value is not given and received.

"Immediate family" shall include parent, mother-in-law, father-in-law, spouse, former spouse, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, child and stepchild. In addition, "immediate family" shall include any other person who is supported, directly or indirectly, to a material extent by a producer.

"Loan" means an agreement to advance property, including but not limited to money, in return for the promise that payment will be made for use of the property.

b. A producer shall not:

(1) Solicit or accept, directly or indirectly, at any time, a personal loan from an insurance customer that in the aggregate exceeds $250, unless the customer is:

1. A bank, savings and loan, credit union or other recognized lending entity; or

2. A member of the producer's immediate family.

(2) Solicit or accept, directly or indirectly, at any time, a gift to the producer or to a member of the producer's immediate family from an insurance customer that in the aggregate exceeds $250, unless the customer is a member of the producer's immediate family. A gift to a member of the producer's immediate family shall be included in calculating the aggregate amount. A gift received by a member of the producer's immediate family from a customer that is not a member of the producer's immediate family in excess of the aggregate amount shall be deemed a violation of this subrule by the producer.

(3) Solicit or accept being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity of a customer, unless the customer is a member of the producer's immediate family.

(4) Evade or otherwise violate the spirit of this subrule by terminating a producer relationship with an insurance customer for the purpose of soliciting or accepting a loan or a gift, or for the purpose of being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity that the producer otherwise would have been prohibited from soliciting or accepting by this subrule. A producer will not be in violation of this subrule if the producer has made a bona fide termination of the producer

relationship with the insurance customer and has conducted no insurance or other business with the insurance customer for a period of three years.

c. Transactions which involve nominal interim ownership immediately precedent to transfer of ownership into a trust are exempt from this subrule.

191—15.9(507B) Right to return a life insurance policy or annuity (free look). The owner of an individual policy has the right, within ten days after receipt of a life insurance policy or annuity, to a free-look period. During this period, the policyowner may return the life insurance policy or annuity to the insurer at its home office, branch office, or to the producer through whom it was purchased. If so returned, the premium paid will be promptly refunded, the policy or annuity voided and the parties returned to the same position as if a policy or annuity had not been issued. If the transaction involved a replacement, the length of the free-look period will be determined according to 191—Chapter 16.

If the transaction involved a variable product, the amount to be refunded shall be determined according to the policy language. The calculations must comply with the relevant rule in either 191—Chapter 16, Replacement of Life Insurance and Annuities, or 191—Chapter 33, Variable Life Insurance Model Regulation.

191—15.10(507B) Uninsured/underinsured automobile coverage—notice required.

15.10(1) *Contents of notice.* Automobile insurance policies delivered in this state shall include a notice which contains and is limited to the following language:

NOTICE REGARDING UNINSURED/UNDERINSURED COVERAGE

Uninsured/underinsured coverage does not cover damage done to your vehicle. It provides benefits only for bodily injury caused by an uninsured or underinsured motorist. If you wish to be insured for damage done to your vehicle, you must have collision coverage. Please check your policy to make sure you have the coverage desired.

15.10(2) *Form of notice.* Notice may be provided on a separate form or may be stamped on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the notice in this rule is required by the insurance division.

191—15.11(507B) Unfair discrimination.

15.11(1) *Sex discrimination.*

a. A contract shall not be denied to an individual based solely on that individual's sex or marital status. No benefits, terms, conditions or type of coverage shall be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured except to the extent permitted under the Iowa Code or Iowa Administrative Code. An insurer may consider marital status for the purpose of defining individuals eligible for dependents' benefits. This subrule does not apply to group life insurance policies or group annuity contracts issued in connection with pension and welfare plans which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

b. Specific examples of practices prohibited by this subrule include, but are not limited to, the following:

(1) Denying coverage to individuals of one sex employed at home, employed part-time or employed by relatives when coverage is offered to individuals of the opposite sex similarly employed.

(2) Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.

(3) Denying a policy under which maternity coverage is available to an unmarried female when that same policy is available to a married female.

(4) Denying, under group contracts, dependent coverage to spouses of employees of one sex, when dependent coverage is available to spouses of employees of the opposite sex.

(5) Denying disability income coverage to employed members of one sex when coverage is offered to members of the opposite sex similarly employed.

(6) Treating complications of pregnancy differently from any other illness or sickness under the contract.

(7) Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one sex.

(8) Offering lower maximum monthly benefits to members of one sex than to members of the opposite sex who are in the same underwriting and occupational classification under a disability income contract.

(9) Offering more restrictive benefit periods and more restrictive definitions of disability to members of one sex than to members of the opposite sex in the same underwriting and occupational classifications under a disability income contract.

(10) Establishing different contract conditions based on gender which limit the benefit options a policyholder may exercise.

(11) Limiting the amount of coverage due to an insured's or prospective insured's marital status unless such limitation applies only to coverage for dependents and is uniformly applied to males and females.

c. When rates are differentiated on the basis of sex, an insurer must, upon the request of the commissioner of insurance, justify the rate differential in writing to the satisfaction of the commissioner. All rates shall be based on sound actuarial principles or a valid classification system and actual experience statistics, if available.

d. This subrule shall not affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this subrule is applicable to the insurance benefits available to its members.

15.11(2) *Physical or mental impairment.* No contract, benefits, terms, conditions or type of coverage shall be denied, restricted, modified, excluded or reduced solely on the basis of physical or mental impairment of the insured or prospective insured except where based on sound actuarial principles or related to actual or reasonably anticipated experience. For purposes of this subrule, both blindness and partial blindness shall be considered a physical impairment.

15.11(3) *Income discrimination.* An insurer shall not refuse to issue, limit the amount or apply different rates to individuals of the same class in the sale of individual life insurance based solely upon the prospective insured's legal source or level of income, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The portion of this subrule pertaining to level of income does not:

a. Apply to the sale of disability income insurance of any kind or of any insurance designed to protect against economic loss due to a disruption in the regular flow of an individual's earned income;

b. Prohibit the sale of any insurance or annuity which is made available only to employees;

c. Prohibit basing the amount of insurance sold to an employee on a multiple or a percentage of the employee's salary or prohibit limiting availability to employees who have achieved a certain employment status as defined by the employer;

d. Prohibit insurers from providing life or health insurance as an incidental benefit through a qualified pension plan;

e. Prohibit insurers from applying suitability standards which include income as a factor in the sale of any life insurance or annuity products;

f. Prohibit insurers from establishing maximum or minimum amounts of insurance that will be issued to individuals so long as this is pursuant to a preexisting specialized marketing strategy which the insurer can demonstrate is related to the financial capacity of the insurer to write business or to bona fide transaction costs.

15.11(4) *Domestic abuse.* A contract shall not be denied to an individual based solely on the fact that such individual has been or is believed to have been a victim of domestic abuse as defined in Iowa Code section 236.2.

15.11(5) *Genetic information.* Any action by an insurer that is not in compliance with Title I of the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881) shall be

considered an unfair trade practice and shall be subject to the penalties of Iowa Code chapter 507B and of these rules.
[**ARC 7796B**, IAB 5/20/09, effective 5/22/09; **ARC 7965B**, IAB 7/15/09, effective 8/19/09]

191—15.12(507B) Testing restrictions of insurance applications for the human immunodeficiency virus.

15.12(1) *Written release.* No insurer shall obtain a test of any individual in connection with an application for insurance for the presence of an antibody to the human immunodeficiency virus unless the individual to be tested provides a written release on a form which contains the following information:

a. A statement of the purpose, content, use, and meaning of the test.

b. A statement regarding disclosure of the test results including information explaining the effect of releasing the information to an insurer.

c. A statement of the purpose for which test results may be used.

15.12(2) *Form.* A preapproved form is provided in Appendix II. An insurer wishing to utilize a form which deviates from the language in the appendix to these rules shall submit the form to the insurance division for approval. Any form containing, but not limited to, the language in the appendix shall be deemed approved.

15.12(3) *Test results.* A person engaged in the business of insurance who receives results of a positive human immunodeficiency virus (HIV) test in connection with an application for insurance shall report those results to a physician or alternative testing site of the applicant's or policyholder's choice or, if the applicant or policyholder does not choose a physician or alternative testing site to receive the results, to the Iowa department of public health.

191—15.13(507B) Records maintenance.

15.13(1) *Complaint and business records.*

a. An insurer shall maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner.

b. An insurer shall maintain a complete record of all the complaints received since the date of its last examination by the insurer's state of domicile or port-of-entry state. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix IV sets forth the minimum information required to be contained in the complaint record.

15.13(2) *Insurer's control over advertisements.* Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements which explain a particular policy. All such advertisements, whether written, created, designed or presented by the insurer or its appointed producer, shall be the responsibility of the insurer whose particular policies are so advertised. As part of this requirement, each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance division. All such advertisements shall be maintained for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

15.13(3) *Education and training materials.* Every insurer shall establish and maintain a system of control over the content and form of all material used by the insurer or any of its employees for the recruitment, training, and education of producers in the sale of insurance. Upon request, copies of these materials shall be made available to the commissioner.

191—15.14(505,507B) Enforcement section—cease and desist and penalty orders.

15.14(1) If, after hearing, the commissioner determines that a person has engaged in an unfair trade practice in violation of these rules, an unfair method of competition, or an unfair or deceptive act or practice in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing

and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring the person to cease and desist from engaging in such method of competition, act or practice. The commissioner also may order one or more of the following:

a. Payment of a civil penalty of not more than $1,000 for each act or violation, but not to exceed an aggregate penalty of $10,000, unless the person knew or reasonably should have known that the actions were in violation of these rules or of Iowa Code chapter 507B, in which case the penalty shall be not more than $5,000 for each act or violation, but not to exceed an aggregate penalty of $50,000 in any one six-month period. If the commissioner finds that a violation of these rules or of Iowa Code chapter 507B was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer;

b. Suspension or revocation of an insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of these rules or of Iowa Code chapter 507B;

c. Payment of interest at the rate of 10 percent per annum if the commissioner finds that the insurer failed to pay interest as required under Iowa Code section 507B.4, subsection 12;

d. Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;

e. Payment of the costs of the investigation and administrative expenses related to any act or violation. The commissioner may retain funds collected pursuant to any settlement, enforcement action, or other legal action authorized under federal or state law for the purpose of reimbursing costs and expenses of the division.

15.14(2) Any person who violates a cease and desist order of the commissioner while such order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or both of the following:

a. A civil penalty of not more than $10,000 for each and every act or violation.

b. Suspension or revocation of such person's license.

191—15.15 to **15.30** Reserved.

DIVISION II
CLAIMS

191—15.31(507B) General claims settlement guidelines. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

191—15.32(507B) Prompt payment of certain health claims. Effective July 1, 2002, the following provisions apply:

15.32(1) *Definitions and scope.*

a. For purposes of this rule, the following definitions apply:

"Circumstance requiring special treatment" means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or

2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or

3. Similar unique or special circumstances which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

"Coordination of benefits for third-party liability" means a claim for benefits by a covered individual who has coverage under more than one health benefit plan.

"Insurer" means insurer as defined in 2001 Iowa Acts, chapter 69, section 7.

"Properly completed billing instrument" means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual, or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

b. Scope. This subrule applies to claims submitted to an insurer as defined above on or after July 1, 2002, and is limited to policies issued, issued for delivery, or renewed in this state.

15.32(2) *Insurer duty to promptly pay claims and pay interest.*

a. Insurers subject to this subrule shall either accept and pay or deny a clean claim for health care benefits under a benefit certificate or policy issued by the insurer within 30 days after the insurer's receipt of such claim. A clean claim is considered to be paid on the date upon which a check, draft, or other valid negotiable instrument is written. Insurers shall implement procedures to ensure that these payments are promptly delivered.

b. Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer's receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer's receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

c. Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

d. Effective January 1, 2003, when a claim involves coordination of benefits, an insurer is required to comply with the requirements of this subrule when that insurer's liability has been determined.

15.32(3) *Certain insurance products exempt.* Claims paid under the following insurance products are exempt from the provisions of this subrule: liability insurance, workers' compensation or similar insurance, automobile or homeowners insurance, medical payment insurance, disability income insurance, or long-term care insurance.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.

191—15.33(507B) Audit procedures for medical claims.

15.33(1) *Prohibitions.* This rule applies to all claims paid on or after January 1, 2002:

a. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

b. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than $25.

15.33(2) *Standards.*

a. In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

b. In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

15.33(3) *Contents of audit request.* All correspondence regarding the audit of a claim must include the following information:

a. The name, address, telephone number and contact person of the insurer conducting the audit,

b. The name of the entity performing the audit if not the insurer,

c. The purpose of the audit, and

d. If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4, subsection 9, as amended by 2001 Iowa Acts, chapter 69.

191—15.34 to **15.40** Reserved.

191—15.41(507B) Claims settlement guidelines for property and casualty insurance. For purposes of this rule, "insurer" means property and casualty insurers.

15.41(1) An insurer shall fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

15.41(2) Within 30 days after receipt by the insurer of properly executed proofs of loss, the first-party property claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing, and the claim file of the insurer shall contain documentation of the denial.

When there is a reasonable basis supported by specific information available for review by the commissioner that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(3) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, the insurer shall so notify the first-party claimant within 30 days after receipt of the proof of loss and give the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

When there is a reasonable basis supported by specific information available for review by the commissioner for suspecting that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(4) Insurers shall not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

15.41(5) No insurer shall make statements indicating that the rights of a third-party claimant may be impaired if a form or release, other than a release to obtain medical records, is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

15.41(6) The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within 30 days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute under one of the coverages and where the payee is known should be tendered within 30 days if such payment would terminate the insurer's known liability under that coverage.

15.41(7) No producer shall conceal from a first-party claimant benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

15.41(8) A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions to exhibit or cooperate in the claim investigation.

15.41(9) No insurer shall deny a claim based upon the failure of a first-party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition. An insurer may deny a claim if the claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

15.41(10) No insurer shall indicate to a first-party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract.

15.41(11) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

191—15.42(507B) Acknowledgment of communications by property and casualty insurers. For purposes of this rule, "insurer" means property and casualty insurers.

15.42(1) Upon receiving notification of a claim, an insurer shall, within 15 days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgment is made by means other than in writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated.

15.42(2) Upon receipt of any inquiry from the Iowa insurance division regarding a claim, an insurer shall, within 21 days of receipt of such inquiry, furnish the division with an adequate response to the inquiry, in duplicate.

15.42(3) The insurer shall reply within 15 days to all pertinent communications from a claimant which reasonably suggest that a response is expected.

15.42(4) Upon receiving notification of claim, an insurer shall promptly provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subrule within 15 days of notification of a claim shall constitute compliance with subrule 15.42(1).

191—15.43(507B) Standards for settlement of automobile insurance claims.

15.43(1) Loss calculation and deviation guidelines.

a. Loss calculation. When the insurance policy provides for the adjustment and settlement of first-party automobile total losses on the basis of actual cash value or replacement with another automobile of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. All applicable taxes, license fees and other fees incident to the transfer of evidence of ownership of the automobile shall be paid by the insurer, at no cost to the insured, other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last 90 days to consumers in the local market area; or

2. The cost of two or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last 90 days to consumers when comparable automobiles are not available in the local market area; or

3. One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles is not available; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

- The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area.
- The source's database shall produce values for at least 85 percent of all makes and models for the last 15 model years taking into account the values of all major options for such vehicles.
- The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to ensure statistical validity.

(3) If the insurer is notified within 35 days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for such market value, the insured shall have a right of recourse. The insurer shall reopen its claim file and the following procedure(s) shall apply:

1. The insurer may locate a comparable vehicle by the same manufacturer, same or newer year, similar body style and similar options and price range for the insured for the market value determined by the insurer at the time of settlement. Any such vehicle must be available through a licensed dealer; or
2. The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured; or
3. The insurer may elect to offer a replacement in accordance with the provisions set forth in subrule 15.43(1); or
4. The insurer may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The insurer is not required to take action under this subrule if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same or newer year, similar body style and similar options in as good or better condition as the total-loss vehicle which could have been purchased for the market value determined by the insurer before applicable deductions. The documentation shall include the vehicle identification number.

b. Deviation. When a first-party automobile total loss is settled on a basis which deviates from the methods described in paragraph *"a,"* the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first-party claimant.

15.43(2) Where liability and damages are reasonably clear, an insurer shall not recommend that third-party claimants make claims under their own policies solely to avoid paying claims under the insurer's policy.

15.43(3) The insurer shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

15.43(4) The insurer shall, upon the claimant's request, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro-rata share of the allocated loss adjustment expense.

15.43(5) Vehicle repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which the insured obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the

difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repair shops, the insurer shall ensure that the repairs are performed according to automobile industry standards. The insurer shall maintain documentation of all such communications.

15.43(6) When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

15.43(7) When the insurer elects to repair an automobile, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy, within a reasonable period of time.

15.43(8) Storage and towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges. The insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay all reasonable towing charges.

15.43(9) Betterment. Betterment deductions are allowable only if the deductions reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle. Betterment deductions must be measurable, itemized, specified as to dollar amount and documented in the claim file.

15.43(10) Diminished value. Rescinded IAB 4/28/04, effective 4/7/04.

191—15.44(507B) Standards for determining replacement cost and actual cost values.

15.44(1) *Replacement cost.* When the policy provides for the adjustment and settlement of first-party losses based on replacement cost, the following shall apply:

a. When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment or any other cost except for the applicable deductible.

b. When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace as much of the item as is necessary to result in a reasonably uniform appearance within the same line of sight. This subrule applies to interior and exterior losses. Exceptions may be made on a case-by-case basis. The insured shall not bear any cost over the applicable deductible, if any.

15.44(2) *Actual cash value.*

a. When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine the actual cash value. "Actual cash value" means replacement cost of property at time of loss, less depreciation, if any. Alternatively, an insurer may use market value in determining actual cash value. Upon the insured's request, the insurer shall provide a copy of the claim file worksheet(s) detailing any and all deductions for depreciation.

b. In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

15.44(3) *Applicability.* This rule does not apply to automobile insurance claims.

191—15.45(507B) Guidelines for use of aftermarket crash parts in motor vehicles.

15.45(1) *Identification.* All aftermarket crash parts supplied for use in this state shall comply with the identification requirements of Iowa Code section 537B.4.

15.45(2) *Like kind and quality.* An insurer shall not require the use of aftermarket crash parts in the repair of an automobile unless the aftermarket crash part is certified by a nationally recognized entity to be at least equal in kind and quality to the original equipment manufacturer part in terms of fit, quality and performance, or that the part complies with federal safety standards.

15.45(3) *Contents of notice.* Any automobile insurance policy delivered in this state that pays benefits based on the cost of aftermarket crash parts or that requires the insured to pay the difference between the cost of original equipment manufacturer parts and the cost of aftermarket crash parts shall include a notice which contains and is limited to the following language:

NOTICE—PAYMENT FOR AFTERMARKET CRASH PARTS

Physical damage coverage under this policy includes payment for aftermarket crash parts. If you repair the vehicle using more expensive original equipment manufacturer (OEM) parts, you may pay the difference. Any warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

15.45(4) *Form of notice.* Notice may be provided on a separate form or may be printed prominently on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application, but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the insurance division requires the notice in this rule.

191—15.46 to **15.50** Reserved.

DIVISION III
DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

191—15.51(507B) Purpose. The purpose of these rules is to ensure the provision of meaningful information to the purchasers of small face amount life insurance policies. The rules in this division apply to all small face amount policies not exempted under rule 15.53(507B) that are issued on or after July 1, 2004.

191—15.52(507B) Definition. *"Small face amount policy"* means a life insurance policy or certificate with an initial face amount of $15,000 or less.

191—15.53(507B) Exemptions. These rules apply to all group and individual life insurance policies and certificates except:

1. Variable life insurance;
2. Individual and group annuity contracts;
3. Credit life insurance;
4. Group or individual policies of life insurance issued to members of an employer group or other permitted group when:
   - Every plan of coverage was selected by the employer or other group representative;
   - Some portion of the premium is paid by the group or through payroll deduction; and
   - Group underwriting or simplified underwriting is used; and
5. Policies and certificates where an illustration has been provided pursuant to the requirements of 191—Chapter 14

191—15.54(507B) Disclosure requirements.

15.54(1) An insurer issuing a small face amount policy shall provide the disclosure included in Appendix IV if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy, but may be delivered with the policy.

15.54(2) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

a. Provide the disclosure only in those circumstances when the premiums may exceed the face amount; or

b. Provide the disclosure for all demographic and benefit combinations.

15.54(3) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

191—15.55(507B) Insurer duties. The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement.

191—15.56 to **15.60** Reserved.

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

191—15.61(507B) Purpose. The purpose of these rules is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and to foster consumer education. The rules specify the minimum information which must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of these rules is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts. The rules in this division apply to all annuities not exempted under rule 15.62(507B) that are issued on or after July 1, 2004.

191—15.62(507B) Applicability and scope. These rules apply to all group and individual annuity contracts and certificates except:

15.62(1) Registered or nonregistered variable annuities or other registered products;

15.62(2) Immediate and deferred annuities that contain no nonguaranteed elements;

15.62(3) Annuities used to fund:

a. An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

b. A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

c. A governmental or church plan defined in Section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

This subrule shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pretax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subrule, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

15.62(4) Structured settlement annuities; and

15.62(5) Charitable gift annuities as defined in Iowa Code chapter 508F.

191—15.63(507B) Definitions. For purposes of these rules:

"Contract owner" means the owner named in the annuity contract or the certificate holder in the case of a group annuity contract.

"Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after the contract is issued. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements. These elements may be described as guaranteed but

not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

"Generic name" means a short title descriptive of the annuity contract for which application is made or an illustration is prepared, such as "single premium deferred annuity."

"Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

"Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges or elements of formulas used to determine any of these elements, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

"Structured settlement annuity" means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

191—15.64(507B) Standards for delivery of disclosure document and Buyer's Guide.

15.64(1) Delivery requirement. When an insurer or an insurance producer receives an application for an annuity contract, the insurer or insurance producer shall provide the applicant the disclosure document described in rule 191—15.65(507B) and the Buyer's Guide to Fixed Deferred Annuities, hereafter "the Buyer's Guide," in the current form prescribed by the National Association of Insurance Commissioners or in language approved by the commissioner of insurance.

15.64(2) Delivery methods. The documents required under this rule may be delivered as follows:

a. When an application for an annuity contract is taken in a face-to-face meeting with an insurance producer, the insurance producer shall provide the disclosure document and the Buyer's Guide at or before the time of application.

b. When an application for an annuity contract is taken by means other than a face-to-face meeting, the insurer shall send the applicant both the disclosure document and the Buyer's Guide no later than five business days after the completed application is received by the insurer.

c. When an application is received as a result of direct solicitation through the mail, the insurer may provide the Buyer's Guide and the disclosure document in the mailing which invites prospective applicants to apply for an annuity contract.

d. When an application is received via the Internet, the insurer may comply with this rule by taking reasonable steps to make the Buyer's Guide and disclosure document available for viewing and printing on the insurer's Web site.

15.64(3) A solicitation for an annuity contract which occurs other than in a face-to-face meeting shall include a statement that the proposed applicant may contact the Iowa insurance division for a free annuity Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer's Guide.

15.64(4) When the Buyer's Guide and disclosure document are not provided at or before the time of application, a free-look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under the state law or rule.

191—15.65(507B) Content of disclosure documents. Insurers shall define terms used in the disclosure statement in language that facilitates understanding by a typical individual within the segment of the public to which the disclosure statement is directed. At a minimum, the following information shall be included in the disclosure document:

15.65(1) The generic name of the contract, the company product name, if different, and form number and the fact that it is an annuity;

15.65(2) The insurer's name and address;

15.65(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, including but not limited to:

a. The guaranteed, nonguaranteed and determinable elements of the contract, and the limitations of those elements, if any, and an explanation of how the elements and limitations operate;

b. An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

c. Periodic income options both on a guaranteed and nonguaranteed basis;

d. Any value reductions caused by withdrawals from or surrender of the contract;

e. How values in the contract can be accessed;

f. The death benefit, if available, and how it will be calculated;

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

h. Impact of any rider, such as a long-term care rider;

15.65(4) Specific dollar amount or percentage charges and fees, listed with an explanation of how they apply; and

15.65(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

191—15.66(507B) Report to contract owners. For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

1. The beginning and ending date of the current report period;
2. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;
3. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and
4. The amount of outstanding loans, if any, as of the end of the current report period.

191—15.67(507B) Severability. If any provision of these rules or their application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rule and its application to other persons or circumstances shall not be affected.

DIVISION V
SUITABILITY IN ANNUITY TRANSACTIONS

191—15.68(507B) Purpose. The purpose of these rules is to require insurers to establish a system to supervise recommendations and to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the times of the transactions are appropriately addressed.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.69(507B) Applicability and scope.

15.69(1) These rules shall apply to any recommendation to purchase, exchange or replace an annuity made to a consumer on or after January 1, 2011, by an insurance producer, or by an insurer where no producer is involved, that results in the purchase, exchange or replacement recommended.

15.69(2) Unless otherwise specifically included, this rule shall not apply to transactions involving:

a. Direct-response solicitations where there is no recommendation based on information collected from the consumer pursuant to these rules.

b. Contracts used to fund the following:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Section 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC) if established or maintained by an employer;

(3) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.70(507B) Definitions. For purposes of this division:

"Annuity" means an annuity that is an insurance product under state law, individually solicited, whether the product is classified as an individual or group annuity.

"Continuing education credit" or *"CE credit"* means one credit as defined in rule 191—11.2(505,522B).

"Continuing education provider" or *"CE provider"* means a CE provider as defined in rule 191—11.2(505,522B).

"FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

"Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

"Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase, exchange or replacement of an annuity in accordance with that advice.

"Replacement" means a transaction in which a new policy or contract is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer if there is no producer, that, by reason of the transaction, an existing policy or contract has been or is to be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase.

"Suitability information" means information that is reasonably appropriate to determine the suitability of a recommendation, including the following:

1. Age;
2. Annual income;
3. Financial situation and needs, including the financial resources used for the funding of the annuity;
4. Financial experience;
5. Financial objectives;
6. Intended use of the annuity;
7. Financial time horizon;
8. Existing assets, including investment and life insurance holdings;
9. Liquidity needs;
10. Liquid net worth;
11. Risk tolerance; and

12. Tax status.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.71(507B) Duties of insurers and of insurance producers.

15.71(1) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs, including the consumer's suitability information, and that there is a reasonable basis to believe all of the following:

a. The consumer has been reasonably informed of various features of the recommended annuity, such as: the potential surrender period and surrender charge; potential tax penalty if the consumer sells, exchanges, surrenders or annuitizes the annuity; mortality and expense fees; investment advisory fees; potential charges for and features of riders; limitations on interest returns; insurance and investment components; and market risk;

b. The consumer would benefit from certain features of the annuity, such as tax-deferred growth, annuitization, death benefit, or living benefit;

c. The particular annuity as a whole, the underlying subaccounts to which funds are allocated at the time of purchase or exchange of the annuity, and riders and similar product enhancements, if any, are suitable (and in the case of an exchange or replacement, the transaction as a whole is suitable) for the particular consumer based on the consumer's suitability information; and

d. In the case of an exchange or replacement of an annuity, the exchange or replacement is suitable, including taking into consideration whether:

(1) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits (such as death benefit, living benefit, or other contractual benefits), or be subject to increased fees, investment advisory fees or charges for riders and similar product enhancements;

(2) The consumer would benefit from product enhancements and improvements; and

(3) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 36 months.

15.71(2) Prior to the execution of a purchase, exchange or replacement of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain the consumer's suitability information.

15.71(3) Except as permitted under subrule 15.71(4), an insurer shall not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity is suitable based on the consumer's suitability information.

15.71(4) Exceptions.

a. Except as provided under paragraph 15.71(4)*"b,"* neither an insurance producer, nor an insurer, shall have any obligation to a consumer under subrule 15.71(1) or 15.71(3) related to any annuity transaction if:

(1) No recommendation is made;

(2) A recommendation was made and was later found to have been prepared based on inaccurate material information provided by the consumer;

(3) A consumer refuses to provide relevant suitability information and the annuity transaction is not recommended; or

(4) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or the insurance producer.

b. An insurer's issuance of an annuity subject to paragraph 15.71(4)*"a"* shall be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

15.71(5) An insurance producer or, where no insurance producer is involved, the responsible insurer representative, shall at the time of sale:

a. Make a record of any recommendation subject to subrule 15.71(1);

b. Obtain a customer-signed statement documenting a customer's refusal to provide suitability information, if any; and

c. Obtain a customer-signed statement acknowledging that an annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the insurance producer's or insurer's recommendation.

15.71(6) An insurer's duty to supervise.

a. An insurer shall establish a supervision system that is reasonably designed to achieve the insurer's and its insurance producers' compliance with rules 191—15.68(507B) through 191—15.75(507B) including, but not limited to, the following:

(1) The insurer shall maintain reasonable procedures to inform its insurance producers of the requirements of these rules and shall incorporate the requirements of these rules into relevant insurance producer training manuals;

(2) The insurer shall establish standards for insurance producer product training and shall maintain reasonable procedures to require its insurance producers to comply with the requirements of rule 191—15.72(507B);

(3) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its insurance producers;

(4) The insurer shall maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that a recommendation is suitable. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(5) The insurer shall maintain reasonable procedures to detect recommendations that are not suitable. These procedures may include, but are not limited to, confirmation of consumer suitability information, systematic customer surveys, interviews, confirmation letters and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures or by confirming suitability information after issuance or delivery of the annuity; and

(6) The insurer shall annually provide a report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

b. Third-party supervisor.

(1) Nothing in this subrule restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under paragraph 15.71(6)*"a."* An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to rule 191—15.73(507B) regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph 15.71(6)*"b"*(2).

(2) An insurer's supervision system under paragraph 15.71(6)*"a"* shall include supervision of contractual performance under this subrule including, but not limited to, the following:

1. Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

2. Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

c. An insurer is not required to include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer.

15.71(7) An insurance producer shall not dissuade, or attempt to dissuade, a consumer from:

a. Truthfully responding to an insurer's request for confirmation of suitability information;

b. Filing a complaint; or

c. Cooperating with the investigation of a complaint.

15.71(8) Compliance with FINRA.

a. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under these rules. This subrule applies to FINRA member broker-dealer sales of variable annuities and fixed annuities if the suitability and supervision are similar to those applied to variable annuity sales. However, nothing in this subrule shall limit the insurance commissioner's ability to enforce (including investigate) the provisions of this regulation.

b. For paragraph 15.71(8)*"a"* to apply, an insurer shall:

(1) Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

(2) Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.72(507B) Insurance producer training.

15.72(1) An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subrule.

15.72(2) Training required.

a. One-time course.

(1) An insurance producer who engages in the sale of annuity products shall complete a one-time four-credit training course approved by the Iowa insurance division and provided by an education provider approved by the insurance division.

(2) Insurance producers may not engage in the sale of annuities until the annuity training course required under this rule has been completed.

b. The minimum length of the training required under this rule shall be sufficient to qualify for at least four CE credits, but may be longer.

c. The training required under this rule shall include information on the following topics:

(1) The types of annuities and various classifications of annuities;

(2) Identification of the parties to an annuity;

(3) How fixed, variable and indexed annuity contract provisions affect consumers;

(4) The application of income taxation of qualified and nonqualified annuities;

(5) The primary uses of annuities;

(6) Appropriate sales practices; and

(7) Replacement and disclosure requirements.

d. Providers of courses intended to comply with this rule shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

e. A provider of an annuity training course intended to comply with this rule shall register as a CE provider in this state and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

f. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with 191—Chapter 11.

g. Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with 191—Chapter 11.

h. Satisfaction of the training requirements of another state that are substantially similar to the provisions of this subrule shall be deemed to satisfy the training requirements of this subrule in this state.

i. An insurer shall verify that an insurance producer has completed the annuity training course required under this subrule before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subrule by obtaining certificates of completion of the training course or obtaining reports provided by Iowa insurance commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved continuing education providers.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.73(507B) Compliance; mitigation; penalties.

15.73(1) An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its insurance producer, the commissioner may order:

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of the rules of this division;

b. A general agency, independent agency or the insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division; and

c. Appropriate penalties and sanctions.

15.73(2) Any applicable penalty under Iowa Code chapter 507B for a violation of the rules in Division V of this chapter may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.74(507B) Record keeping.

15.74(1) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for ten years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

15.74(2) Records required to be maintained by this rule may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.
[**ARC 8934B**, IAB 7/14/10, effective 1/1/11]

191—15.75 to **15.79** Reserved.

DIVISION VI
INDEXED PRODUCTS TRAINING REQUIREMENT

191—15.80(507B,522B) Purpose. The purpose of the rules in this division is to require certain specific minimum training for insurance producers who wish to sell indexed annuities or indexed life insurance in Iowa. This additional training is necessary due to the complex nature of these indexed products and to ensure that insurance producers are able to determine whether an indexed product is suitable for a consumer and are able to adequately explain to a consumer how the indexed product works. The ultimate goal of these rules is to ensure that purchasers of indexed products understand basic features of the indexed products. The rules in this division apply to all indexed products sold on or after January 1, 2008.

191—15.81(507B,522B) Definitions. For the purpose of this division:

"CE credit" means one continuing education "credit" as defined in 191—Chapter 11.

"CE provider" means any individual or entity that is approved to offer continuing education courses in Iowa pursuant to 191—Chapter 11.

"Indexed products" means all fixed indexed life insurance and fixed indexed annuity products.

"Insurer" means an insurance company admitted to do business in Iowa which sells indexed products in Iowa.

"Producer" means a person required to obtain an insurance license under Iowa Code chapter 522B.

191—15.82(507B,522B) Special training required. A producer who wishes to sell indexed products in Iowa shall complete at least one four-credit indexed products training course, as described in this division, prior to providing any advice or making any sales presentation concerning an indexed product.

191—15.83(507B,522B) Conduct of training course.

15.83(1) The indexed products training shall include information on all topics listed in the most recent version of the indexed products training outline available at the division's Web site, www.iid.state.ia.us.

15.83(2) CE providers of indexed products training shall cover all topics listed in the indexed products training outline and, within the time allotted for the required topics, shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

15.83(3) The minimum length of the indexed products training must be sufficient to qualify for at least four CE credits, but may be longer.

15.83(4) To satisfy the requirements of subrules 15.83(1), 15.83(2) and 15.83(3), an indexed products training course shall be filed, approved and conducted according to the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

15.83(5) Indexed products training courses may be conducted and completed by classroom or self-study methods according to the rules in 191—Chapter 11.

15.83(6) CE providers of indexed products training shall comply with the reporting requirements as set forth in 191—Chapter 11.

15.83(7) CE providers of indexed products training shall issue certificates of completion according to the rules in 191—Chapter 11.

15.83(8) A producer may use the CE credits completed under the indexed products training requirement to meet the producer's continuing education requirement under 191—Chapter 11.

191—15.84(507B,522B) Insurer duties.

15.84(1) Each insurer shall establish a system to verify which of its appointed insurance producers have completed one training course on indexed products as required in this division.

15.84(2) An insurer shall verify that a producer has completed the required indexed products training before allowing the producer to sell an indexed product for that insurer.

15.84(3) For insurance producers under contract with or employed by a broker-dealer, general agent or independent agency, an insurer may enter into a contract with the broker-dealer, general agent or independent agency to establish and maintain a system of verification as required by subrule 15.84(1) with respect to those insurance producers. In such circumstances, the insurer shall make reasonable inquiry to ensure that the broker-dealer, general agent or independent agency is performing the functions required under subrules 15.84(1) and 15.84(2).

191—15.85(507B,522B) Verification of training. Insurers, producers and third-party contractors may verify a producer's completion of the indexed products training by accessing the division's Web site at www.iid.state.ia.us.

191—15.86(507B,522B) Penalties.

15.86(1) Insurers and third-party contractors that violate the rules of this division are subject to penalty under Iowa Code chapter 507B.

15.86(2) Producers who violate the rules of this division are subject to penalty under Iowa Code chapters 507B and 522B.

15.86(3) Continuing education providers that fail to follow the requirements of the rules of this division and the conduct requirements of 191—Chapter 11 are subject to penalty under 191—Chapter 11 and Iowa Code chapters 507B and 522B.

191—15.87(507B,522B) Compliance date.

15.87(1) A producer who provides advice or makes a sales presentation regarding an indexed product on or after January 1, 2008, shall have completed the indexed products training required by this division.

15.87(2) An Iowa-licensed insurer shall verify that, prior to the sale of any indexed products on or after January 1, 2008, any producer appointed by the insurer has completed the indexed products training required by this division.

Appendix I
LIFE INSURANCE COST AND BENEFIT DISCLOSURE

Definitions.

"Annual premium" for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

"Cash dividend" means dividends which can be applied toward payment of gross premiums which comply with the illustrated scale.

"Equivalent level annual dividend" is calculated by applying the following steps:

1. Accumulate the annual cash dividends at 5 percent interest compounded annually to the end of the tenth and twentieth policy years.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
3. Divide the results of paragraph "2" by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death other than suicide, or other specifically enumerated exclusions, at the beginning of each policy year for 10 and 20 years at 5 percent interest compounded annually to the end of the tenth and twentieth policy years respectively.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

"Generic name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

"Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

1. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.
2. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at 5 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph "1."
3. Divide the result of subparagraph "2" (subparagraph "1" for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph "2" (subparagraph "1" for guaranteed-cost policies) over the respective periods stipulated in subparagraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
4. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5 percent interest compounded annually to the end of the period stipulated in subparagraph "1" and dividing the result by the respective factors stated in subparagraph "3" (this amount is the annual premium payable for a level premium plan).
5. Subtract the result of subparagraph "3" from subparagraph "4."
6. Divide the result of subparagraph "5" by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

"Policy summary," for the purposes of these rules, shall mean a written statement describing the elements of the policy including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

2. The name and address of the insurance producer or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

4. The generic name of the basic policy and each rider.

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide and other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate.

7. Life insurance cost indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's illustrated scale and are not guaranteed and a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

11. The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph "5" of this definition shall be listed in total, not a per-thousand nor a per-unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

Appendix II
HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next ten years.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. Positive test results. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

a. False positives: This test gives a positive result, even though you are not infected. This happens rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

4. Side effects. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results become known to others. A negative result may create a false sense of security.

5. Disclosure of results. A positive test result will be reported to you in one of the following ways. You may choose to have information about a positive test result communicated to you through your physician or through the alternative testing site. If you do not designate a physician or an alternative testing site to receive the information, the information about a positive test result will be reported to the Iowa Department of Public Health, and the Iowa Department of Public Health will contact you.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by calling the national AIDS hotline at 1-800-342-2437.

INFORMED CONSENT

I hereby authorize the company and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.

a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the company.

2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.

b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If the third ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third blood or other bodily fluid test is negative, a negative result will be reported to the company.

3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as a positive. All other results will be reported as negative to the company.

Without a court order or written authorization from me, these results will be made known only to the company and its reinsurers (if involved in the underwriting process). The company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Screen will be disclosed only to my physician or an alternative testing site as I direct below. If I do not designate a physician or alternative testing site to receive the results, the company will provide results of a positive HIV test to the Iowa Department of Public Health. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice which I received as a part of the application process. The only information the company will report to MIB, Inc. is that positive results were obtained from a blood or other bodily fluid test. The company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. Positive HIV Antibody Screen results are to be reported to: (elect one) □ the Alternative Testing Site or □ my physician; _____

(name and address of attending physician)

This authorization will be valid for 90 days from the date below.

Dated At: _____Day _____ Month _____, 19 _____

Witness _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

Appendix III
COMPLAINT RECORD

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition after Complaint Received	Date Received	Date Closed	Insurance Division Complaint	State of Origin
(Producer's Number)								

Explanation

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number, name, or other means of identifying any licensee of the Insurance Division, such as a producer that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.
Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1) Underwriting
   a) Premium and rating
   b) Refusal to insure
   c) Cancellation/renewal
   d) Delays
   e) Unfair discrimination
   f) Endorsement/rider
   g) Group conversion
   h) Medicare supplement violation
   i) Miscellaneous (not covered by above)
2) Marketing and Sales
   a) General advertising
   b) Misrepresentation
   c) Producer handling
   d) Replacement
   e) Delays
   f) Miscellaneous (not covered by above)
3) Claims
   a) Post claim underwriting
   b) Delays
   c) Unsatisfactory settlement/offer
   d) Coordination of benefits
   e) Cost containment
   f) Denial of claim
   g) Miscellaneous (not covered by above)
4) Policyholder service
   a) Premium notice/billing
   b) Cash value
   c) Delays/no response
   d) Premium refund
   e) Coverage question
   f) Miscellaneous (not covered by above)
5) Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved as follows:
1) Automobile
2) Fire
3) Homeowners-Farmowners
4) Crop
5) Life and Annuity
6) Accident and Health
7) Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.
The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities:
1. Policy issued/restored.
2. Refund.
3. Claim settled.
4. Delay resolved.
5. Question of fact.
6. Contract provision/legal issue.
7. No jurisdiction.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the com plaint was from an insurance department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

Appendix IV
DISCLOSURE FORM FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

Important Information About Your Policy

The premiums you'll pay for your policy may be more than the amount of your coverage (the face amount). You can find both the face amount and the annual premium in your policy. Look for the page labeled [use the label the company uses for that information, such as "Statement of Policy Cost and Benefit Information"].

- Usually, you can figure out how many years it will take until the premiums paid will be greater than the face amount. For an estimate, divide the face amount by the annual premium. Several factors may affect how many years this might take for *your* policy. These include not paying premiums when due, taking out a policy loan, surrendering your policy for cash, policy riders, payment of dividends, if applicable, and changes in the face amount.
- Many factors will affect how much your life insurance costs. Some are your age and health, the face amount of the policy, and the cost of a policy rider. You may be able to pay less for your insurance if you answer health questions. You may also pay less if you pay your premiums less often.
- Ask your insurance agent or your insurance company if you have any questions about your premiums, your coverage, or anything else about your policy.

If You Change Your Mind . . .

- You can get a full refund of premiums you've paid if you return your policy and cancel your coverage. You *must* do this within the number of days stated on your policy's front page. To return the policy for a full refund, send it back to the agent or the company.
- If you stop paying premiums or cancel your policy *after* the time that a full refund is available, you have specific rights. Ask your insurance agent or your insurance company about your rights.

Contact Information

If you have questions about your insurance policy, ask your agent or your company. If your agent isn't available, contact your insurance company at [provide telephone number (including toll-free number if available), address and Web site (if available)].

These rules are intended to implement Iowa Code chapters 507B and 522B.

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◊ Two or more ARCs

1 The Administrative Rules Review Committee at their February 13, 1979, meeting delayed the effective date of rules 15.90 to 15.93 seventy days.

2 Effective date (12/31/81) of rules 15.9 and 15.31 delayed 70 days by the Administrative Rules Review Committee.

3 At its meeting held August 13, 2003, the Administrative Rules Review Committee voted to delay the effective date of 15.43(10) until adjournment of the 2004 Session of the General Assembly.

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]

CHAPTER 1
ORGANIZATION

CHAPTER 2
INVESTMENT BOARD

CHAPTER 3
BENEFITS ADVISORY COMMITTEE

CHAPTER 4
EMPLOYERS

CHAPTER 5
EMPLOYEES

CHAPTER 6
COVERED WAGES

CHAPTER 7
SERVICE CREDIT AND VESTING STATUS

CHAPTER 8
SERVICE PURCHASES

CHAPTER 9
REFUNDS

CHAPTER 10
INTEREST ON ACCUMULATED CONTRIBUTIONS

CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS

CHAPTER 12
CALCULATION OF MONTHLY RETIREMENT BENEFITS

CHAPTER 13
DISABILITY FOR REGULAR AND SPECIAL SERVICE MEMBERS

CHAPTER 14
DEATH BENEFITS AND BENEFICIARIES

CHAPTER 15
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CHAPTER 16
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CHAPTER 17
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

CHAPTERS 27 to 29
Reserved

CHAPTER 30
PETITIONS FOR RULE MAKING

CHAPTER 31
AGENCY PROCEDURE FOR RULE MAKING

CHAPTER 4
EMPLOYERS
[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. *"Political subdivision"* means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. *"Instrumentality of the state or a political subdivision"* means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. *"Public agency"* means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

a. Former name;
b. Former address;
c. IPERS account number;
d. New name, address, and telephone number of the employer;
e. Reason for the change if other than a change of reporting official; and
f. Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

a. Complete name and address of the dissolved entity;
b. Assigned IPERS account number;
c. Last date on which wages were paid;
d. Date on which the entity dissolved;
e. Reason for the dissolution;
f. Whether or not the entity expects to pay wages in the future;
g. Whether the entity is being absorbed by another covered employer;
h. Name and address of absorbing employer if applicable; and
i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Records shall show with respect to each employee:

a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
c. Total amount of wages paid on each date including noncash wage equivalents;
d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.
b. Effective July 1, 1991, employers must report all terminating employees to IPERS within seven working days following the employee's termination date. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.
c. Effective December 31, 2004, and annually thereafter, employers whose job classes include correctional officers, correctional supervisors, and others whose primary purpose is, through ongoing direct inmate contact, to enforce and maintain discipline, safety and security within a correctional facility shall submit to IPERS each calendar year a list of jobs that qualify for protection occupation class coverage. This report shall also contain any changes in the designation of jobs as qualifying or not qualifying for protection occupation class coverage and effective dates of changes. IPERS' sole responsibility with respect to protection occupation status determinations is to ascertain whether IPERS' records correctly reflect service credit and contributions that are in accordance with the employer's designation of a position as being within a protection occupation class.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) *Payment of contributions.* For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS covered employer, the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via the IPERS' employer self service Web application, on compact discs, or as a paper report. However, for those employers submitting reports on compact discs or on paper, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or holiday, the contribution or report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the report or timely pay because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self service Web application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of $20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self service Web application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee

is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code section 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

495—4.4(97B) Accrual of interest and application of employer payments. Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of $20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) Credit memos voided. Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) Contribution rates. The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) Contribution rates for regular class members.

a. Effective July 1, 2007, except as otherwise provided by law, the following contribution rates shall be effective for all covered members except those identified in subrules 4.6(2) and 4.6(3):

	Ended June 30, 2007	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010
Combined rate	9.45%	9.95%	10.45%	10.95%	11.45%
Employer	5.75%	6.05%	6.35%	6.65%	6.95%
Employee	3.70%	3.90%	4.10%	4.30%	4.50%

b. Effective July 1, 2011, and every year thereafter, the contribution rates shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective no later than July 1 of the next fiscal year.

4.6(2) Contribution rates for sheriffs and deputy sheriffs.

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010
Combined rate	15.40%	15.04%	15.24%	17.88%
Employer	7.70%	7.52%	7.62%	8.94%
Employee	7.70%	7.52%	7.62%	8.94%

4.6(3) Contribution rates for protection occupation.

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010
Combined rate	14.11%	14.08%	15.34%	16.59%
Employer	8.47%	8.45%	9.20%	9.95%
Employee	5.64%	5.63%	6.14%	6.64%

4.6(4) Members employed in a "protection occupation" shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a "correctional officer" position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another "correctional officer" position that meets this definition. Movement to a position that does not meet this definition shall cancel "protection occupation" coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a "peace officer" by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[**ARC 7591B**, IAB 2/25/09, effective 7/1/09; **ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09; **ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, termination date and last check date, when appropriate, and employer identification number.

For new employee enrollments submitted on or after August 1, 2008, employers shall submit the required information using IPERS' employer self service Web application, on compact discs, or on paper. However, those employers submitting information on compact discs or on paper will be charged a fee as described in subrule 4.3(6).

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Effective January 1, 2009, this rule applies to the restoration of covered wages reduced by an employer-mandated reduction in hours (EMRH) or the restoration of covered wages reduced by the exercise of bumping rights to avoid a layoff. It does not apply to reductions in base wages, reduced overtime wages, permanent layoffs or other termination of employment situations. EMRH references in this rule shall apply both to situations involving the loss of covered wages due to employer-mandated reductions in hours and to the loss of covered wages due to the exercise of bumping rights to avoid a layoff.

4.8(1) A member may restore the member's three-year average covered wage to the amount that it would have been but for an EMRH by completing the IPERS EMRH application form and related payroll deduction authorization and by filing the application and payroll deduction authorization forms with the employer. By so doing, the member agrees to pay the employee and employer contributions for all reduced work hours and bumping reductions between January 1, 2009, through June 30, 2011.

4.8(2) A member cannot pay the EMRH contributions described under this rule in any manner except through payroll deductions.

4.8(3) The payroll deduction authorization described under this rule shall be irrevocable, except upon death, retirement or termination of employment. If revoked by the member's death, retirement, or termination of employment, all amounts held by an employer in the member's name shall be forwarded to the member along with the member's final wages.

4.8(4) A member may obtain a refund of EMRH contributions collected under this rule as part of a refund of the member's entire account balance or an actuarial equivalent (AE) payment, but a member who commences a monthly retirement allowance shall not receive a refund of any amounts contributed, even if the covered wages being restored are not used in the member's three-year average covered wage.

4.8(5) A covered employer must cooperate with an eligible member's request for payroll deductions using the applicable IPERS forms. Employers shall be required to complete and submit wage certifications showing the covered wages that would have been reported but for the EMRH.

4.8(6) After IPERS has received and processed wage certification forms, the employer will be billed for the applicable EMRH contributions on the next employer monthly statement. If contributions are not paid by the employer statement's due date, the employer will be assessed late fees and interest in accordance with rule 495—4.3(97B).

4.8(7) In completing the federal and state wage reporting forms to be filed with the federal and state tax authorities, an employer shall treat the EMRH contributions collected and forwarded to IPERS the same as pretax IPERS employee contributions.

4.8(8) Upon receipt of the contributions pursuant to this rule, IPERS shall apply them to the member's account as pretax employee contributions.

4.8(9) This rule applies to reductions in wages caused by an EMRH through June 30, 2011. An employer's collection of contributions from such wages shall terminate as of midnight, July 31, 2011.

All completed EMRH forms and contributions collected under this rule must be forwarded to IPERS by a covered employer no later than August 15, 2011.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09; **ARC 8929B**, IAB 7/14/10, effective 6/21/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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CHAPTER 6
COVERED WAGES
[Prior to 6/9/04, see 581—Ch 21]

495—6.1(97B) IRS requirements. Wages as discussed in this chapter shall not exceed the amount permitted for a given year under Section 401(a)(17) of the Internal Revenue Code.

495—6.2(97B) Definition of wages. "Wages" means all compensation earned by employees including, except as otherwise provided under this chapter, vacation pay; sick pay; back pay; amounts deducted from the employee's pay at the employee's discretion for tax-sheltered annuities, dependent care and cafeteria plans; and the cash value of wage equivalents. This definition applies to these rules, regulations, interpretations, forms and other IPERS publications unless the context otherwise requires.

495—6.3(97B) IPERS coverage for various forms of compensation. The following is a list of various types of compensation and the corresponding IPERS coverage treatment:

6.3(1) *Vacation pay or annual leave pay.* Vacation pay or annual leave pay means the amount paid to an employee during a period of vacation.

6.3(2) *Sick pay.* Sick pay means payments made for sick leave which are a continuation of salary payments.

6.3(3) *Workers' compensation payments and other third-party payments.* Workers' compensation payments, unemployment payments, or short-term and long-term disability payments made by an insurance company or third-party payer, such as a trust, are not included as wages. Payments for sick leave which are a continuation of salary payments if paid from the employer's general assets, regardless of whether the employer labels the payments as sick leave, short-term disability, or long-term disability, are covered wages.

6.3(4) *Compensatory time.* Wages include amounts paid for compensatory time taken in lieu of regular work hours or when paid as a lump sum. However, compensatory time paid in a lump sum shall not exceed 240 hours per employee per year or any lesser number of hours set by the employer. Each employer shall determine whether to use the calendar year or a fiscal year other than the calendar year when setting its compensatory time policy.

6.3(5) *Banked holiday pay.* If an employer codes banked holiday time as holiday or additional accrued vacation time, the banked holiday pay will be vacation pay under subrule 6.3(1). If an employer codes banked holiday time as compensatory time, the banked holiday pay will be combined with compensatory pay and subject to the limits set forth in subrule 6.3(4).

6.3(6) *Special lump sum payments.* Wages do not include special lump sum payments made during or at the end of service as a payoff of unused accrued sick leave or of unused accrued vacation. Wages do not include special lump sum payments made during or at the end of service as an incentive to retire early or as payments made upon dismissal, severance, or a special bonus payment intended as an early retirement incentive. Wages do not include: catastrophic leave paid in a lump sum, bonuses, tips or honoraria. Exclusion of payments as described in this subrule applies whether the payment is in a lump sum or in installments.

6.3(7) *Covered wage treatment for supplemental payments.*

a. Payments excluded from covered wages as bonuses include the following:

(1) Recruitment payments.

(2) Retention payments.

(3) Payments to members who achieve improvements in their employer's financial status or performance ratings.

(4) Employee performance incentive payments.

(5) Extraordinary job performance payments.

(6) Payments for the possession, attainment, or maintenance of special skills or professional certifications (does not apply to advancements in a member's placement in wage or salary schedule, or placement in a higher tier wage or salary schedule).

(7) Payments to members made in lieu of merit increases because the members' wage or salary scales are capped.

(8) Payments similar in substance to those enumerated above without regard to the payments' titles, tag lines, labels or classifications by employers.

b. Payments included in covered wages that are not to be treated as bonuses include the following:

(1) Payments authorized by statute and used to increase the general level of teacher pay, except as otherwise provided in this subrule (for example, when such moneys are used to pay retention bonuses).

(2) Payments for which additional, or new and different, job duties are required in order to receive the payment.

(3) Payments for employment longevity.

c. Payments that are otherwise to be treated as covered wages under paragraph *"b"* shall not be covered if IPERS determines that the payments are made for paragraph *"a,"* subparagraphs (1) to (8), of this subrule or other subrules, including, but not limited to, recruitment or retention bonuses, retirement incentive and severance payments, reimbursements of business expenses, and payment of allowances.

d. IPERS shall have the final authority to determine if supplemental payments not described in paragraphs *"a,""b"* and *"c"* of this subrule should be treated as excluded bonus payments or covered wages. In making its determination, IPERS may consider, but is not limited to, such factors as the supplemental payments' similarity to payments described in paragraphs *"a,""b"* and *"c"* of this subrule, whether such payments are discretionary with the employer, and whether, on the one hand, the payments are regular and periodic over the working careers of a broad group of individuals or, on the other hand, are short-term, irregular, or ad hoc payments whose primary effect is to spike certain members' final average salaries.

6.3(8) *Other special payment arrangements.* Wages do not include amounts paid pursuant to special arrangements between an emplyoer and employee whereby the employer pays increased wages and the employee reimburses the employer or a third-party obligor for all or part of the wage increase. This limitation includes, but is not limited to, the practice of increasing an employee's wages by the employer's share of health care costs and having the employee reimburse the employer or a third-party provider for such health care costs. Wages do not include amounts paid pursuant to a special arrangement between an employer and employee whereby wages in excess of the covered wage ceiling for a particular year are deferred to one or more subsequent years. Wages do not include employer contributions to a plan, program, or arrangement that are not included in the employee's federal taxable income. However, certain employer contributions under IRC Section 125 plans are permitted to be treated as covered wages under rule 495—6.5(97B) subject to the terms of that rule.

Employers and employees that knowingly and willfully enter into the types of arrangements described in this subrule, causing an impermissible increase in the payments authorized under Iowa Code chapter 97B, may be prosecuted under Iowa Code section 97B.40 for engaging in a fraudulent practice. If IPERS determines that its calculation of a member's monthly benefit includes amounts paid under an arrangement described in this subrule, IPERS shall recalculate the member's monthly benefit, after making the appropriate wage adjustments. IPERS may recover the amount of overpayments caused by the inclusion of the payments described in this subrule from the monthly amounts plus interest payable to the member or amounts payable to the member's successor(s) in interest, regardless of whether or not IPERS chooses to prosecute the employers and employees under Iowa Code section 97B.40.

6.3(9) *Wage equivalents.* Items such as food, lodging and transportation are includable as employee income, if they are paid as compensation for employment. The basic test is whether or not such wage equivalent was given for the convenience of the employee or employing unit. Wage equivalents are not reportable under IPERS if given for the convenience of the employing unit or are not reasonably quantifiable. Wage equivalents that are not included in the member's federal taxable income shall be deemed to be for the convenience of the employer. A wage equivalent is not reportable if the employer certifies that there was a substantial business reason for providing the wage equivalent, even if the wage equivalent is included in the employee's federal taxable income. Wages paid in any other form than money are measured by the fair market value of the meals, lodging, travel or other wage equivalents.

6.3(10) *Members of the general assembly.* Wages for a member of the general assembly means the total compensation received by a member of the general assembly, whether paid in the form of per diem or annual salary. Wages include per diem payments paid to members of the general assembly during interim periods between sessions of the general assembly. Wages do not include expense payments except that, effective July 1, 1990, wages include daily allowances to members of the general assembly for nontravel expenses of office during a session of the general assembly. Such nontravel expenses of office during a session of the general assembly shall not exceed the maximum established by law for members from Polk County. A member of the general assembly who has elected to participate in IPERS shall receive four quarters of service credit for each calendar year during the member's term of office, even if no wages are reported in one or more quarters during a calendar year.

6.3(11) *Wages restored following an employer-mandated reduction in hours.* Notwithstanding rule 495—6.4(97B), wages restored following the receipt of contributions forwarded pursuant to 495—4.8(97B) shall be credited to quarters in which the wages would have been received but for the employer-mandated reduction in hours (EMRH).

6.3(12) *Wages paid as a back pay settlement.* IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 6.3(6) and shall not be covered.

6.3(13) *Limitations on benefits and contributions.*

a. Section 415(b) limitations on benefits. A member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Internal Revenue Code Sections 415(b) and 415(d). For purposes of applying the limits under Internal Revenue Code Section 415(b) (Limit), the following will apply:

(1) With respect to a member who does not receive a portion of the member's annual benefit in a lump sum:

1. The member's Limit will be applied to the member's annual benefit in the first limitation year without regard to any automatic cost-of-living increases;

2. To the extent the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases under the IPERS trust fund until such time as the benefit plus the accumulated increases are less than the applicable Limit; and

3. Thereafter, in any subsequent limitation year, the member's annual benefit including any automatic cost-of-living increase shall be tested under the then applicable benefit Limit, including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d) (cost-of-living adjustments) and the regulations thereunder; and

(2) With respect to a member who receives a portion of the member's annual benefit in a lump sum:

1. The member's applicable Limit shall be applied taking into consideration automatic cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations; and

2. In no event shall a member's annual benefit payable under the system in any limitation year be greater than the Limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder. If the form of benefit without regard to the automatic benefit increase feature is not a straight life or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent straight life annuity benefit determined using the assumptions required by Treasury Regulations, including the mortality table specified in Revenue Ruling 2001-62 or Revenue Ruling 2007-67, as applicable.

b. Section 415(c) limitations on contributions and other member additions. Member contributions and other additions paid to the system may not exceed the annual limits on contributions and other additions allowed by Internal Revenue Code Section 415(c). For purposes of applying these limits, the definition of "compensation," where applicable, will be compensation as defined in Treasury Regulation Section 1.415(c)-2(d)(3), or successor regulation. The foregoing definition of compensation will exclude member contributions picked up under Internal Revenue Code Section 414(h)(2) and, for plan years beginning after December 31, 1997, compensation will include the amount of any elective deferrals, as defined in Internal Revenue Code Section 402(g)(3), and any amount contributed or deferred by the employer at the election of the member and which is not includible in the gross income of the member by reason of Internal Revenue Code Section 125 or 457 and, for plan years beginning on and after January 1, 2001, pursuant to Internal Revenue Code Section 132(f)(4).

c. Limitation year. The limitation year is the calendar year.

6.3(14) *Employer payments treated as remuneration counted against the reemployment earnings limit.* All taxable or nontaxable compensation, regardless of the title, tag line, label, or classification attributed to that compensation paid by IPERS-covered employers to retired reemployed IPERS members, shall be considered remuneration when determining reemployment earnings limits and reductions as set forth under Iowa Code section 97B.48A and rule 495—12.8(97B). This rule shall apply whether the compensation is paid pursuant to individual contracts or otherwise, and regardless of whether it is considered covered or noncovered compensation under Iowa Code section 97B.1A(26) and the administrative rules thereunder, except for:

a. Contributions to health insurance plans and programs, and

b. Reimbursements of actual work-related expenses required by the retired reemployed members' jobs.

6.3(15) *Employer contributions as remuneration counted against the reemployment earnings limit.* Employer contributions made on behalf of retired reemployed members to tax qualified and nonqualified retirement and deferred compensation plans and to other fringe benefit arrangements, excluding health insurance plans and programs, shall constitute remuneration from employment which shall be applied to the reemployment earnings limits and reductions set forth under rule 495—12.8(97B). Such contributions, even if counted as remuneration hereunder, shall not be counted as covered wages, unless the facts in the particular case indicate that, under the circumstances, the arrangement should be treated as covered wages under rules 495—6.1(97B) through 495—6.5(97B). Nonelective employer contributions to the following shall constitute remuneration when determining reemployment earnings limits: tax qualified retirement and deferred compensation plans; all nonqualified retirement plans and deferred compensation arrangements; IRAs; rabbi, secular, and other trust arrangements; split dollar and other life insurance arrangements; and long-term care insurance.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—6.4(97B) Month for which wages are to be reported. Wages are reportable for the month in which they are actually paid to the employee, except when employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, receive lump sum payments of extra duty pay, or request wage restorations following EMRH, and similar situations involving regular and periodic lump sum payments which IPERS in its sole discretion determines should be treated as covered wages. The employer shall file wage adjustment reporting forms with IPERS allocating the wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

6.4(1) Actual and constructive receipt. An employer cannot report wages as having been paid to employees as of a monthly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as June wages, but wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as July wages.

6.4(2) One quarter of service will be credited for each quarter in which a member is paid IPERS covered wages.

a. "Covered wages" means wages of a member during periods of service that do not exceed the annual covered wage maximum as permitted for a given year under Section 401(a)(17) of the Internal Revenue Code.

b. Effective January 1, 1988, covered wages shall include wages paid a member regardless of age. (From July 1, 1978, until January 1, 1988, covered wages did not include wages paid a member on or after the first day of the month in which the member reached the age of 70.)

c. If a member is employed by more than one employer during the calendar year, the total amount of wages paid by all covered employers shall be included in determining the annual covered wage limit established under Section 401(a)(17) of the Internal Revenue Code. If the amount of wages paid to a member by several employers during any given month exceeds the covered wage limit as determined for that calendar year, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. IPERS shall not accept excess wages and applicable contributions from employers and shall return excess contributions as provided in 495—subrule 4.3(8).

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—6.5(97B) Covered wage treatment for employer contributions to IRC Section 125 plans. If certain conditions are met, employer contributions to fringe benefit programs that qualify under IRC Section 125 may be treated as covered wages. The following subrules set forth IPERS' regulations for determining covered wage treatment and for making wage adjustments when employer-paid contributions have been covered or excluded in violation of the standards set forth below.

6.5(1) *Section 125 plans.* For purposes of this rule, a Section 125 plan means an employer-sponsored fringe benefit plan that is subject to Section 125 of the federal Internal Revenue Code. Some of the common names for this type of plan are cafeteria plan, flexible benefits plan, flex plan, and flexible spending arrangement.

6.5(2) *Elective employer contributions.* For purposes of this rule, "elective employer contributions" means employer contributions made to a Section 125 plan that can be received in cash or used to purchase benefits under the Section 125 plan. Generally, elective employer contributions that are not subject to special eligibility requirements qualify as covered wages.

6.5(3) *Mandatory minimum coverage requirements.* The term "elective employer contributions" does not include employer contributions that must be used to purchase benefits under a Section 125 plan. For example, if an employer provides $2,500 to its employees to purchase benefits in a Section 125 plan, but requires that all employees must use $1,000 of that amount to purchase single health coverage, the cost of the single coverage is deducted. In this example, $1,000 would be subtracted from the $2,500 provided, resulting in $1,500 of covered wages.

6.5(4) *Uniformity determined coverage group by coverage group.* Iowa Code section 97B.1A(26)*"a"*(1)*"b"* states that elective employer contributions shall be treated as covered wages only if made uniformly available and not limited to highly compensated employees. The application of the uniformity concept may be illustrated as follows: Employer Z has two major groupings of employees covered under its cafeteria plan: teaching staff and support staff. Every member of the teaching staff is provided $3,000 to purchase benefits under the Section 125 plan. Every member of the teaching staff must take single coverage costing $1,500. Every member of the support staff is provided $2,500 and must also take the single coverage costing $1,500. Each member of the teaching staff would have $1,500 treated as covered wages, and each member of the support staff would have $1,000 treated as covered wages. This would be considered uniform treatment.

Uniformity is not destroyed by the fact that the amount available to members of a coverage group varies because the actual cost of mandatory minimum coverage varies depending on actuarial factors that apply to each individual. For example, assume Employer Z above also requires each employee to have long-term disability coverage. In Employer Z's case, the actual cost of disability coverage will vary from individual to individual. In that case, Employer Z would also deduct the actual cost of the required disability coverage, individual by individual, when determining IPERS covered wages.

Uniformity is not destroyed if an employer has two groups of employees who, as a result of collective bargaining, have differing entitlements to employer contributions. For example, Employer Y has a contract that provides $3,500 to each employee to purchase benefits under the Section 125 plan. Every employee may take all the cash by waiving participation in the plan, or may use all or part of the employer contributions to the Section 125 plan. In the collective bargaining process, a new contract is adopted which states that the employer will still provide $3,500 to each employee to purchase benefits under the Section 125 plan. However, under the new contract, persons who waived participation before April 15 may still waive participation in the plan and take all the cash, but persons who did not waive participation and those hired after April 15 must have single coverage costing $1,700. Employer Y would be treated as having two groups of employees with different elective employer contribution amounts. The grandfathered group (employees who waived participation before April 15) would have covered wages of $3,500, and the group consisting of those who did not waive participation before April 15 and new employees would have covered wages of $1,800.

6.5(5) *Highly compensated employee test.* Iowa Code chapter 97B provides that, in addition to being uniformly available, employer contributions must not discriminate in favor of highly compensated employees (HCEs). For purposes of this subrule, an HCE is an employee who has reported wages and tips subject to Medicare tax in excess of the IRC Section 414(q) limit then in effect. IPERS shall apply the HCE limitation as follows. If elective employer contributions are made available to HCEs, the total elective employer contributions made available to the HCE group must not exceed 25 percent of the total elective employer contributions made available under the Section 125 plan to all employees, including the HCEs. If the elective employer contributions available to the HCE group exceed the 25 percent limit (or if it is determined that the Section 125 plan discriminates in favor of HCEs under other IRS rules), elective employer contributions for HCEs shall not exceed the highest amount available to a nonexecutive coverage group of employees covered under such plan. The general application of these principles is illustrated below, using the 2002 IRC Section 414(q) dollar limit of $90,000.

Employer W has a Section 125 plan that provides elective employer contributions totaling $7,000 to executive staff, $4,500 to teaching staff, and $3,500 to support staff. There are no other limits or exclusions that apply. These amounts are treated as covered wages for each member of each group, provided that the total amount of contributions made available to HCEs does not exceed 25 percent of the total elective employer contributions for all employees covered under the plan. If elective employer contributions for the executive staff totaled $70,000, and total elective employer contributions for the remainder of the staff totaled $500,000, the HCE percentage of total elective employer contributions would be 12 percent ($70,000 divided by $570,000), and all elective employer contributions would be treated as covered wages for all groups. However, if elective employer contributions for the executive staff totaled $70,000, and elective employer contributions for the remainder of the staff totaled $200,000, the HCE percentage would be 26 percent ($70,000 divided by $270,000), and HCEs' elective employer contributions would be limited to $4,500 per HCE for covered wage purposes.

6.5(6) *Elective employer contributions limited to dual coverage employees.* In some cases, a Section 125 plan provides for what appear to be mandatory employer contributions for health plan coverage, but the terms of the Section 125 plan permit dual coverage employees to waive coverage and receive the employer contributions in cash, if the employee can prove coverage under another health care plan. IPERS shall continue to treat the full amount of employer contributions in such cases as not being IPERS covered wages, even though individual employees with the described dual coverage may actually receive the employer contribution in cash.

6.5(7) *Corrections for overpayments and underpayments of contributions and benefits caused by Section 125 plan covered wage errors.* IPERS shall use the following guidelines in requiring corrections for overpayments and underpayments of contributions and benefits caused by the erroneous inclusion or exclusion of employer contributions to a Section 125 plan. Corrections must be made for all active, terminated and retired members, subject to the following limitations:

a. If elective employer contributions that should have been covered were not covered, wage adjustments shall be filed, and employers shall be billed for all shortages plus interest. Employers shall be entitled to collect reimbursement for the employee share of contributions as provided in Iowa Code

section 97B.9. If retirement benefits, death benefits or refunds have been underpaid as a result of the error, IPERS shall, upon receipt of the contribution shortage, make the appropriate adjustments and pay all back benefits.

b. If employer contributions that should not have been covered were covered, wage adjustments shall be filed, and the appropriate contribution amounts shall be repaid to employers for distribution to the respective employee and employer contributors. If the reporting error caused an overpayment of retirement benefits, death benefits, or refunds, IPERS shall offset excess contributions received against overpayments and shall request a repayment of the remainder of the overpayment, if any, from the recipient.

Wage adjustments, overpayments, and underpayments and unintentional reporting errors shall be determined as of the onset of the error, but shall be limited to three years before the beginning of the current contract year for school employers, or current fiscal year for all other covered employers. IPERS may go back to the onset of the error, even if the period exceeds three years, if the error is caused by intentional misconduct or gross neglect. Notwithstanding the foregoing adjustment and collection standards, IPERS reserves the right to negotiate adjustments with individual employers in special situations, and no negotiated settlement with an employer shall be deemed to constitute a waiver of this rule or a binding precedent for other employers.

6.5(8) *Bounties.*

a. Effective prior to June 21, 2010, in some cases, an employer has a Section 125 plan with employer contributions, and what IPERS refers to as a bounty option. A bounty is an amount that may be elected by all employees, or by a subset of that group, such as employees with coverage under another health care plan, either in lieu of any coverage under the employer's health care plan, or in lieu of family coverage. A bounty is generally set at an amount that is less than the amount that would otherwise be available to purchase benefits under the Section 125 plan. IPERS does not treat bounties as covered wages. The uniformity and nondiscrimination principles described in subrule 6.5(4) do not apply to such benefits.

b. Paragraph *"a"* no longer applies effective June 21, 2010. An employer that has relied on the bounty rule to exclude bounty payments from covered wages shall have until September 1, 2010, to bring payroll processes and prospective wage coverage into compliance. No retroactive adjustment shall be required for employers that relied on paragraph *"a"* for periods prior to September 1, 2010.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10]

These rules are intended to implement Iowa Code sections 97B.1A(26), 97B.9, 97B.11, 97B.14 and 97B.14A.

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CHAPTER 9
REFUNDS
[Prior to 11/24/04, see 581—Ch 21]

495—9.1(97B) Refunds for members with only one type of service credit. A member is eligible for a refund of the employee accumulated contributions as soon as practicable after the last date the member is considered an employee, provided that the employee has filed the required forms and has not returned to covered employment before the date the refund is paid. Effective July 1, 1999, a vested member's refund shall also include a portion of the employer accumulated contributions. Refund amounts are determined as follows:

9.1(1) Employee accumulated contributions. Upon receiving an eligible member's application for refund, IPERS shall pay to the terminated member the amount of the employee accumulated contributions currently reported to, and processed by, IPERS as of the date of the refund. Upon reconciliation of the final employee contributions for that member, a supplemental refund of the employee accumulated contributions will be paid if funds remain in the member account.

9.1(2) Employer accumulated contributions. IPERS shall also pay to vested members, in addition to the employee accumulated contributions, a refund of a portion of the employer accumulated contributions. The refundable portion shall be calculated by multiplying the employer accumulated contributions by the "service factor." The "service factor" is a fraction, the numerator of which is the member's quarters of service and the denominator of which is the "applicable quarters." The "applicable quarters" shall be 120 for regular members and 88 for all special service members.

All quarters of service credit shall be included in the numerator of the service factor. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

In addition to the foregoing provisions, IPERS shall calculate the refundable portion of the employer accumulated contributions as follows:

a. Upon reconciliation of the final employer contributions for that member, the member's portion of the employer accumulated contributions will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the service factor. The adjusted service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of employer accumulated contributions to be included in the supplemental refund.

b. The member's portion of employer accumulated contributions shall be determined under rule 9.2(97B) if the member had a combination of regular service and special service, or a combination of different types of special service.

9.1(3) In making calculations under this rule and rule 9.2(97B), IPERS shall round to not less than six decimal places to the right of the decimal point.

495—9.2(97B) Refunds for members eligible for a hybrid refund. The calculation of the member's portion of employer accumulated contributions for a "hybrid refund" shall be as follows:

9.2(1) A "hybrid refund" is a refund that is calculated for a member who has a combination of regular service and special service quarters.

9.2(2) If a member is eligible for a hybrid refund, the member's portion of employer accumulated contributions shall be calculated by multiplying the total employer accumulated contributions by: (a) the member's regular service factor, if any; and (b) the special service factor, if any (except as otherwise provided in this subrule). The amounts obtained will be added together to determine the amount of the employer accumulated contributions payable. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

9.2(3) Upon reconciliation of the final contributions from a member's employer, the member's portion of the employer accumulated contributions under this rule will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the applicable service factor. The adjusted

service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of the employer accumulated contributions to be included in the supplemental refund.

9.2(4) If wages reported for a quarter are a combination of regular and special service wages, IPERS will classify the service credit for each quarter based on the largest dollar amount reported for that quarter. A member shall not receive more than one quarter of service credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

9.2(5) If a member is last employed in a sheriff or deputy sheriff position, all quarters of "eligible service" shall be counted as quarters of sheriff or deputy sheriff service credit.

9.2(6) A special limitation applies to hybrid refunds where the member and employer contributed at regular rates for quarters that are eligible for coverage under Iowa Code section 97B.49B or Iowa Code section 97B.49C. If a member has regular service credit and special service credit and any part of the special service credit consists of quarters for which only regular contributions were made, such quarters will be counted as regular service quarters. However, the foregoing limitation will not apply if the member only has service credit eligible for coverage under Iowa Code section 97B.49B or only has service credit eligible for coverage under Iowa Code section 97B.49C.

495—9.3(97B) Refund of retired reemployed members' contributions. Rescinded IAB 7/14/10, effective 6/21/10.

495—9.4(97B) General administrative provisions. In addition to the foregoing, IPERS shall administer a member's request for a refund as follows:

9.4(1) To obtain a refund, a member must file a refund application form, which is available directly from IPERS or which can be reprinted from IPERS' Web site www.ipers.org. Effective December 31, 2002, refund application forms shall only be available from IPERS.

9.4(2) The last date the member is considered an employee and the date of the last paycheck from which IPERS contributions will be deducted must be certified by the employer on the refund application unless the member has not been paid covered wages for at least one year. Terminated employees must keep IPERS advised in writing of any change in address so that refunds and tax documents may be delivered.

9.4(3) Unless otherwise specified by the member, the refund warrant will be mailed to the member at the address listed on the application for refund. If a member so desires, the warrant may be delivered to the member or the member's agent at IPERS' principal office. The member must show verification of identification by presenting a picture identification containing both name and social security number. If a member designates in writing an agent to pick up the refund warrant, the agent must present to IPERS both the written designation and the described picture identification.

9.4(4) No payment of any kind is required under this rule if the amount due is less than $1.

9.4(5) Effective July 1, 2004, an employee must sever all covered employment for 30 days after the date the employee was last considered an employee, and not for 30 days after the date of the last paycheck containing IPERS covered wages.

9.4(6) Effective November 2006, an individual who previously stopped participating in IPERS to begin participating in an alternative plan shall not receive a refund of that individual's IPERS account while still employed by a covered employer, even if the member is no longer in IPERS covered employment.

495—9.5(97B) Reinstatement following an employment dispute. If an involuntarily terminated employee takes a refund and is later reinstated in covered employment as a remedy for an employment dispute, the member may reinstate membership service credit for the period covered by the refund by repaying the amount of the refund plus interest within 90 days after the date of the order or agreement requiring reinstatement. A reinstatement following an employment dispute shall not constitute a violation of Iowa Code section 97B.53(4), even if the reinstatement occurs less than 30 days after the

date of termination. Accordingly, the reinstatement described above or, if later, a buy-back, shall be permitted but is not required. However, if the employee is retroactively reinstated and the previously reported termination is expunged, the reemployment shall be treated as falling within the scope of Iowa Code section 97B.53(4) and a previously paid refund shall be repaid with interest.

495—9.6(97B) Refund followed by commencement of disability benefits under Iowa Code section 97B.50(2). If a vested member terminates covered employment, takes a refund, and is subsequently approved for disability under the federal Social Security Act or the federal Railroad Retirement Act, the member may reinstate membership service credit for the period covered by the refund by paying the actuarial cost as determined by IPERS' actuary. Repayments must be made by:

1. For members whose federal social security or railroad retirement disability payments begin before July 1, 2000, within 90 days after July 1, 2000; or

2. For members whose social security or railroad retirement disability payments begin on or after July 1, 2000, within 90 days after the date federal social security or railroad retirement payments begin.

These rules are intended to implement Iowa Code sections 97B.50 and 97B.53.

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CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS
[Prior to 11/24/04, see 581—Ch 21]

495—11.1(97B) Application for benefits.

11.1(1) *Form used.* It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed, sent by fax or brought in person to IPERS. An application that is incomplete or incorrectly completed will be returned to the member. To be considered complete, an application must include the following:

a. Proof of date of birth for the member.

b. Option selected, and

(1) If Option 1 is selected, the death benefit amount.

(2) If Option 4 or 6 is selected, the contingent annuitant's name, gender, social security number, proof of date of birth, and relationship to member.

(3) If Option 1, 2, or 5 is selected, a list of beneficiaries.

c. If the member is disabled, a copy of the award letter from social security or railroad retirement and a statement that the member is retiring due to disability.

d. If the member has been terminated less than one year, the employer certification page must be completed by the employer.

e. Signature of member and spouse, both properly notarized.

f. If the member has no spouse, "NONE" must be designated.

A retirement application is deemed to be valid and binding when the first payment is paid. Members shall not cancel their applications, change their option choice, or change an IPERS option containing contingent annuitant benefits after that date.

11.1(2) *Proof required in connection with application.* Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate or an infant baptismal certificate. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

a. United States census record;

b. Military record or identification card;

c. Naturalization record;

d. A marriage license showing age of applicant in years, months and days on date of issuance;

e. A life insurance policy;

f. Records in a school's administrative office;

g. An official form from the United States Immigration and Naturalization Service, such as the "green card," containing such information;

h. Driver's license or Iowa nondriver identification card;

i. Adoption papers;

j. A family Bible record. A photostatic copy will be accepted with certification by a notary that the record appears to be genuine; or

k. Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

If the member, the member's representative, or the member's beneficiary is unable or unwilling to provide proof of birth, or in the case of death, proof of death, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, Iowa division

of records and statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

11.1(3) *Benefits estimates.* Prior to submitting an application for benefits, a member may request IPERS to prepare estimates of projected benefits under the various options as described under Iowa Code section 97B.51. A benefit estimate shall not bind IPERS to payment of the projected benefits under the various options specified in Iowa Code chapter 97B. A member cannot rely on the benefit estimate in making any retirement-related decision or taking any action with respect to the member's account, nor shall IPERS assume any liability for such actions. A member's actual benefit can only be known and officially calculated when an eligible member applies for benefits.

11.1(4) *Revocation of application.* If IPERS determines an application for benefits is invalid for any reason, IPERS shall revoke, in whole or in pertinent part, the application for benefits and the recipient shall repay all payments made under the revoked application or all payments made pursuant to the revoked part of the application. The terms of repayment shall be subject to the provisions of 495—11.7(97B).

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—11.2(97B) Retirement benefits and the age reduction factor.

11.2(1) *Normal retirement.*

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55 and is otherwise eligible.

11.2(2) *Early retirement.* A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service and the member is otherwise eligible.

11.2(3) *Aged 70 and older retirees.* A member shall be eligible to receive monthly retirement benefits with no age reduction effective with the first day of the month in which the member attains the age of 70, even if the member continues to be employed.

11.2(4) *Required beginning date.*

a. Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required beginning date" specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the application for benefits. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The "required beginning date" is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 70½, or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

b. If IPERS distributes a member's benefits without the member's consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS

in writing within 60 days of the first mandatory distribution. IPERS shall inform the member which adjustments or repayments are required in order to make the change.

c. If a member cannot be located to commence payment on or before the required beginning date described above, the member's benefit shall be forfeited. However, if a member later contacts IPERS and wishes to file an application for retirement benefits, the member's benefits shall be reinstated.

d. For purposes of determining benefits, the life expectancy of a member, a member's spouse, or a member's beneficiary shall not be recalculated after benefits commence.

e. If an IPERS member has a qualified domestic relations order (QDRO) or an administrable domestic relations order (ADRO) on file when a mandatory distribution is required, and the QDRO or ADRO requires the member to choose a specific retirement option, IPERS shall pay benefits under the option required by the order.

11.2(5) *Mandatory distribution of small inactive accounts.* As soon as practicable after July 1, 2004, IPERS shall distribute small inactive accounts to members and beneficiaries as authorized in Iowa Code section 97B.48(5).

11.2(6) *Federal tax code limitation for selection of survivor percentages for same gender spouses.* Benefits payable to members who name a same gender spouse or same gender former spouse as contingent annuitant under Option 4 or 6 shall be subject to the incidental death benefit limitations of Internal Revenue Code Section 401(a)(9)(G).

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—11.3(97B) First month of entitlement (FME).

11.3(1) *General.* A member shall submit a written application to IPERS setting forth the retirement date, provided the member has attained at least age 55 by the retirement date and the retirement date is after the member's last day of service. A member's first month of entitlement shall be no earlier than the first day of the first month after the member's last day of service or, if later, the month provided for under subrule 11.3(2). No payment shall be made for any month prior to the month the completed application for benefits is received by IPERS.

If a member files a retirement application but fails to select a valid first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member's address.

11.3(2) *Additional FME provisions.*

a. Effective through December 31, 1992, the first month of entitlement of a member who qualifies for retirement benefits is the first month following the member's date of termination or last day of leave, with or without pay, whichever is later.

b. Effective January 1, 1993, the first month of entitlement of an employee who qualifies for retirement benefits shall be the first month after the employee is paid the last paycheck, if paid more than one calendar month after termination. If the final paycheck is paid within the month after termination, the first month of entitlement shall be the month following termination.

c. Effective January 1, 2001, employees of a school corporation who are permitted by the terms of their employment contracts to receive their annual salaries in monthly installments over periods ranging from 9 to 12 months may retire at the end of a school year and receive trailing wages through the end of the contract year if they have completely fulfilled their contract obligations at the time of retirement. For purposes of this paragraph, "school corporation" means body politic described in Iowa Code sections 260C.16 (community colleges), 273.2 (area education agencies) and 273.1 (K-12 public schools). For purposes of this paragraph, "trailing wages" means previously earned wage payments made to such employees of a school corporation after the first month of entitlement. This exception does not apply to hourly employees, including those who make arrangements with their employers to hold back hourly wages for payment at a later date, to employees who are placed on sick or disability leave or leave of absence, or to employees who receive lump sum leave, vacation leave, early retirement incentive pay or any other lump sum payments in installments.

For all employees of all IPERS covered employers who terminate employment in January 2003, or later, if the final paycheck is paid within the same quarter or within one quarter after termination and wages are reported under the normal pay schedule, the first month of entitlement shall be the month following termination. However, if the last paycheck is paid more than one quarter after the termination, the first month of entitlement shall be the first month after the employee is paid the last paycheck. Under no circumstances shall such trailing wages result in more than one quarter of service credit being added to retiring members' earning records.

11.3(3) *Survival into designated FME.* To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

11.3(4) *Members retiring under the rule of 88.* The first month of entitlement of a member qualifying under the rule of 88 shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

495—11.4(97B) Termination of monthly retirement allowance. A member's retirement benefit shall terminate after payment is made to the member for the entire month during which the member's death occurs. Death benefits shall begin with the month following the month in which the member's death occurs.

Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retired member and if further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs at law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs at law, or other interested parties.

495—11.5(97B) Bona fide retirement and bona fide refund.

11.5(1) *Bona fide retirement—general.* To receive retirement benefits, a member under the age of 70 must officially leave employment with all IPERS covered employers, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits. Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions, temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to or during the member's first month of entitlement, entered into contractual arrangements with the employer to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period will be waived, however, if the member is elected to public office which term begins during the normal four-month bona fide retirement period. This waiver does not apply if the member was an elected official who was reelected to the same position for another term. The bona fide retirement period will also be waived for state legislators who terminate their nonlegislative employment and the IPERS coverage for their legislative employment and begin retirement but wish to continue with their legislative duties.

A member will have a bona fide retirement if the member returns to work as an independent contractor with a public employer during the four-month qualifying period. Independent contractors are not covered under IPERS.

Effective July 1, 1998, through June 30, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered by 495—Chapter 4, is terminated and the member receives at least four monthly benefit payments. In order to receive retirement benefits, the member must file a completed application for benefits with IPERS before returning to any employment with the same employer.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits before returning to any employment with a covered employer.

11.5(2) *Bona fide retirement—licensed health care professionals.* For retirees whose first month of entitlement is no earlier than July 2004 and no later than June 2012, a retiree who is reemployed as a "licensed health care professional" by a "public hospital" does not have a bona fide retirement until all employment with covered employers is terminated for at least one calendar month. In order to receive retirement benefits, the member must file a completed application for benefits form before returning to any employment with a covered employer.

"Licensed health care professional" means a public employee who is a physician, surgeon, podiatrist, osteopath, psychologist, physical therapist, physical therapist assistant, nurse, speech pathologist, audiologist, occupational therapist, respiratory therapist, pharmacist, social worker, dietitian, mental health counselor, or physician assistant who is required to be licensed under Iowa Code chapter 147.

"Public hospital" means a governmental entity of a political subdivision of the state of Iowa that is authorized by legislative authority. For purposes of this subrule, a "public hospital" must also meet the requirements of Iowa Code section 249J.3. Under Iowa Code section 249J.3, a "public hospital" must be licensed pursuant to Iowa Code chapter 135B and governed pursuant to Iowa Code chapter 145A(merged hospitals), Iowa Code chapter 347 (county hospitals), Iowa Code chapter 347A (county hospitals payable from revenue), or Iowa Code chapter 392 (creation by city of a hospital or health care facility). For the purposes of this definition, "public hospital" does not include a hospital or medical care facility that is funded, operated, or administered by the Iowa department of human services, Iowa department of corrections, or board of regents, or the Iowa Veterans Home.

A "public hospital" possesses the powers conferred upon it by statute, the Iowa Constitution, and regulatory provisions that are unique to governmental entities and hospitals. For example, a "public hospital" may finance its activities by tax levies or the issuance of bonds, condemn property, hold elections, and join forces with other governmental entities in cooperative ventures that are authorized under Iowa Code chapter 28D and Iowa Code chapter 28E. "Public hospitals" are subject to scrutiny by the public by complying with Iowa Code chapter 21 (open meetings Act) and Iowa Code chapter 22(open records Act). Public employees of a "public hospital" are covered by Iowa Code chapter 20 (public employment relations Act). A "public hospital" can be distinguished from a profit or not-for-profit hospital by examining whether the focus of the hospital is community service with profits being applied not to rates of return to investors, but to enhance community services, facility upgrading, or subsidized care for persons unable to pay the full cost of service.

This subrule only applies to reemployments that meet all the foregoing requirements and in addition occur following a "complete termination of employment." A "complete termination of employment" means: (1) the employer must post the opening and conduct a job search; (2) the retired member must

receive all termination payouts that are mandatory for other terminated employees of that employer; (3) the retired member must give up all perquisites of seniority, to the extent applicable to all other terminated employees of that employer; and (4) the retired member must not enter into a reemployment agreement with the prior employer or another public hospital as defined in this subrule prior to or during the first month of entitlement.

11.5(3) *Bona fide refund.* The 30-day bona fide refund period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)*"a"*(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)*"a"*(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS covered employment prior to the issuance of the refund. Such an official may remain in the elective office and receive an IPERS refund without violating IPERS' bona fide refund rules. If such elected official terminates coverage for the elective office and also terminates all other IPERS covered employment but is then reemployed in covered employment, and has not received a refund as of the date of hire, the refund shall not be made. Furthermore, if such elected official is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the public official shall not be eligible for new IPERS coverage for such elected position.

The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official is reelected to the same position without an intervening term out of office. The waiver granted in this subrule shall be applicable to such elected officials who were in violation of the prior bona fide refund rules on and after November 1, 2002, when such individuals have not repaid the previously invalid refund.

If a member takes a refund in violation of the bona fide refund requirements of Iowa Code section 97B.53(4), the member shall have 30 days from the date of written notice by IPERS to repay the refund in full without interest. Thereafter, in order to receive service credit for the period covered by the refund, the member shall be required to buy back the period of service at its full actuarial cost.

11.5(4) *Part-time appointed members of boards or commissions receiving minimal noncovered wages.* Solely for purposes of determining whether a member has severed all employment with all covered employers and has remained out of employment as required under Iowa Code section 97B.52A, persons who have been appointed as part-time members of boards or commissions prior to or during their first month of entitlement and who receive only per diem and reimbursements for reasonable business expenses for such positions will be deemed not to be in employment prohibited under Iowa Code section 97B.52A.

For purposes of this subrule, per diem shall not exceed the amount authorized under Iowa Code section 7E.6(1)*"a"* for members of boards, committees, commissions, and councils within the executive branch of state government. This limit shall apply regardless of whether or not the position in question is within the executive branch of state government.

Members of boards and commissions not exempted under this subrule include: (a) those who are entitled to the payment of per diem regardless of attendance at board or commission meetings, and (b) those who would have received per diem in excess of the amount authorized under Iowa Code section 7E.6(1)*"a"* were it not for an agreement by the member to waive such compensation.

Persons appointed as part-time board or commission members who receive only per diem as set forth above and reimbursements of reasonable business expenses may continue in or accept appointments to such positions without violating the bona fide retirement rules under Iowa Code section 97B.52A.

11.5(5) *Members of the national guard who are called into state active duty.* Effective May 25, 2008, members of the national guard who are called into state active duty as defined in Iowa Code section 29A.1 in noncovered positions during the required period of complete severance will not be in violation of the bona fide retirement requirements of Iowa Code section 97B.52A as amended by 2010 Iowa Acts, House File 2518, section 33.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10]

495—11.6(97B) Payment processing and administration.

11.6(1) *Paper warrants processing fee.* Effective July 1, 2005, IPERS shall charge a per-warrant processing fee to members who choose to receive paper warrants in lieu of electronic deposits of their monthly retirement allowance. The fee may be waived if the person establishes that it would be an undue hardship for the person to do what is necessary to receive payment of the person's IPERS monthly retirement allowance by electronic deposit. The processing fee will be deducted from the member's retirement allowance on a posttax basis.

For purposes of this subrule, a member claiming undue hardship must establish that the cost normally assessed for the processing of paper warrants would be unduly burdensome because of the member's limited income, or is otherwise financially burdensome or physically impracticable.

11.6(2) *Repeated requests for replacement warrants.* Effective July 1, 2002, for a member or beneficiary who, due to the member's or beneficiary's own actions or inactions, has benefits warrants replaced twice in a six-month period, except when the need for a replacement warrant is caused by IPERS' failure to mail to the address specified by the recipient, payment shall be suspended until such time as the recipient establishes a direct deposit account in a bank, credit union or similar financial institution and provides IPERS with the information necessary to make electronic transfer of said monthly payments. Persons subject to said cases may be required to provide a face-to-face interview and additional documentation to prove that such a suspension would result in an undue hardship.

11.6(3) *Forgery claims.* When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

11.6(4) *Rollover fees.* Effective January 1, 2007, if the recipient of a lump-sum distribution which qualifies to be rolled over requests that a rollover be made to more than one IRA or other qualified plan, IPERS may assess a $5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax.

11.6(5) *Offsets against amounts payable.* IPERS may, with or without consent and upon reasonable proof thereof, offset amounts currently payable to a member or the member's designated beneficiaries, heirs, assigns or other successors in interest by the amount of IPERS benefits paid in error to or on behalf of such member or the member's designated beneficiaries, heirs, assigns or other successors in interest.

495—11.7(97B) Overpayment of IPERS benefits.

11.7(1) *Overpayments—general.*

a. An "overpayment" means a payment of money by IPERS that results in a recipient receiving a higher payment than the recipient is entitled to under the provisions of Iowa Code chapter 97B.

b. A "recipient" is a person or beneficiary, heir, assign, or other successor in interest who receives an overpayment from an IPERS benefit and is liable to repay the amount(s) upon receipt of a written explanation and request for the amounts to be repaid.

c. If IPERS determines that the cost of recovering the amount of an overpayment is estimated to exceed the overpayment, the repayment may be deemed to be unrecoverable.

d. If the overpayment is equal to or less than $50 and cannot be recovered from other IPERS payments, IPERS may limit its recovery efforts to written requests for repayment and other nonjudicial remedies.

11.7(2) *Overpayment made to a retired member.* A retired member shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and a limited opportunity to repay the overpayment in full without interest. If a retired member repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. A retired member may repay an overpayment out of pocket or direct IPERS to recover the overpayment from future retirement benefit payments, or a combination of both. If the retired member cannot repay an overpayment in full, either out of pocket or from the next monthly installment of retirement benefits, or both, interest shall be charged. A retired member who cannot repay the full amount of the overpayment within 30 days after the date of the notice must enter into an agreement with IPERS to make monthly installment payments,

or to have the overpayment offset against future monthly benefit payments or death benefits, if any, and authorize any unpaid balance as a first priority claim in the recipient's estate.

11.7(3) *Overpayment made to a person other than a retired member.* A recipient other than a retired member, except a recipient listed in subrule 11.7(4), shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. If such a recipient repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. If such a recipient cannot repay an overpayment in full within 30 days after the date of the notice, interest shall be charged. If repayment in full cannot be made within 30 days, such a recipient shall make repayment arrangements subject to IPERS' approval within 30 days of the written notice and request for repayment.

If the overpayment recipient cannot be located to receive notice of the overpayment at the recipient's last-known address, IPERS shall, after trying to locate the person, consider the recipient to have waived entitlement to the quarters covered by the refund.

11.7(4) *Overpayment made to a person who violates a bona fide severance period.* If a recipient takes a refund and does not complete the required period of severance, the recipient shall receive a written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. The recipient shall have 30 days after the date of notice to repay the full amount of the refund without interest. If the repayment is not made within 30 days after the date of notice, the person shall receive no credit for the period of employment covered by the refund and shall be required to buy back the refund at its actuarial cost if the member later decides that the member wants service credit for any portion of the period of employment covered by the refund.

11.7(5) *Interest charges.*

a. Overpayment not fraudulent. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was not the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent, or the rate IPERS determines, on the outstanding balance, beginning 30 days after the date of notice of the overpayment(s) is provided by IPERS.

b. Overpayments as the result of fraud. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent on the outstanding balance, beginning on the date of the overpayment(s).

c. Overpayments that result in a judgment. In addition to other remedies, IPERS may file a civil action to recover overpayments, and the interest rate may be set by the court.

11.7(6) *Recovery of overpayment from a deceased recipient.* If a recipient dies prior to the full repayment of an erroneous overpayment of benefits, IPERS shall be entitled to apply to the estate of the deceased to recover the remaining balance.

11.7(7) *Offsets against amounts payable.* IPERS may, in addition to other remedies and after notice to the recipient, request an offset against amounts owing to the recipient by the state according to the offset procedures pursuant to Iowa Code sections 8A.504 and 421.17.

11.7(8) *Rights of appeal.* A recipient who is notified of an overpayment and required to make repayments under this rule may appeal IPERS' determination in writing to the chief executive officer. The written request must explain the basis of the appeal and must be received by IPERS' office within 30 days of overpayment notice pursuant to 495—Chapter 26.

11.7(9) *Release of overpayment.* IPERS may release a recipient from liability to repay an overpayment, in whole or in part, if IPERS determines that the receipt of overpayment is not the fault of the recipient, and that it would be contrary to equity and good conscience to collect the overpayment.

No release of an individual recipient's obligation to repay an overpayment shall stand as precedent for release of another recipient's obligation to repay an overpayment.
[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9A, 97B.15, 97B.25, 97B.38, 97B.40, 97B.45, 97B.47, 97B.48, 97B.48A, 97B.49A to 97B.49I, 97B.50, 97B.51, 97B.52, 97B.52A, 97B.53, and 97B.53B.

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CHAPTER 13
DISABILITY FOR REGULAR AND SPECIAL SERVICE MEMBERS
[Prior to 11/24/04, see 581—Ch 21]

495—13.1(97B) Disability for persons retiring under Iowa Code section 97B.50(2).

13.1(1) For IPERS regular class members retiring because of a disability:

a. The member must indicate on the application for retirement that the retirement is due to an illness, injury or similar condition.

b. The member must be awarded federal social security benefits due to a disability which existed at the time the application for retirement was filed.

c. Effective July 1, 1990, the member may also qualify for the IPERS disability provision by being awarded, and commencing to receive, disability benefits through the federal Railroad Retirement Act, 45 U.S.C. Section 231 et seq., due to a disability which existed at the time of retirement.

d. The period for which up to 36 months of retroactive payments under Iowa Code section 97B.50(2) shall be paid is for up to 36 months preceding the month in which such completed application for IPERS disability is received by IPERS. In no event shall retroactive disability benefits payments under Iowa Code section 97B.50(2) precede the month the member actually receives the member's first social security or railroad retirement disability payment. The member shall provide IPERS with a copy of the Social Security Administration award letter showing dates of eligibility.

e. Continued qualification monitoring. For a member retiring due to a disability on or after January 1, 2009, in order to continue qualification for disability benefits, the member shall provide IPERS with proof of continuing eligibility for federal social security disability benefits or railroad retirement disability benefits by June 30 of each calendar year. IPERS may also require complete copies of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if these records are not timely provided.

13.1(2) If a member returns to covered employment after achieving a bona fide retirement, the benefits being provided to the member under Iowa Code section 97B.50(2) *"a"* or *"b"* shall be suspended or reduced as follows. If the member has not attained the age of 55 upon reemployment, benefit payments shall be suspended in their entirety until the member subsequently terminates employment, applies for, and is approved to receive benefits under the provisions of Iowa Code chapter 97B. If the member has attained the age of 55 or older upon reemployment, the member shall continue to receive monthly benefits adjusted as follows. Monthly benefits shall be calculated under the same benefit option that was first selected, based on the member's age, years of service, and the applicable reductions for early retirement as of the month that the member returns to covered employment. The member's benefit shall also be subject to the applicable provisions of Iowa Code section 97B.48A pertaining to reemployed retired members.

13.1(3) Upon terminating a reemployment that resulted in the suspension of all or a portion of the member's disability retirement allowance, the member's benefits shall be recomputed under Iowa Code section 97B.48A and rule 495—12.8(97B). To requalify for a monthly retirement allowance under Iowa Code section 97B.50(2), the member must furnish a new or updated Social Security Administration disability award letter, or other acceptable documentation from the Social Security Administration, indicating that the member is currently eligible for social security disability benefits.

13.1(4) If a member whose IPERS disability benefits were suspended because of the member's return to covered employment provides proof acceptable to IPERS that the member remains eligible for federal social security disability benefits or railroad retirement disability benefits, IPERS shall reinstate the member's disability benefits, subject to the member's continued compliance with paragraph 13.1(1) *"e."*

495—13.2(97B) Disability claim process for special service members. Except as otherwise indicated, this rule shall apply only to disability claims initiated under Iowa Code section 97B.50A. Except as otherwise indicated, disability claims under Iowa Code section 97B.50(2) shall be administered under rule 495—13.1(97B).

13.2(1) *Initiation of disability claim.* The disability claim process shall originate as an application to the system by the member. The application shall be forwarded to the system's designated retirement benefits officer. An application shall be sent upon request to members who qualify pursuant to Iowa Code section 97B.50A(13). The application consists of the following sections which must be completed and returned to the system's designated retirement benefits officer:

1. General applicant information.
2. Applicant's statement.
3. Employer's statement.
4. Member's assigned duties.
5. Disability/injury reports.
6. Medical information release.

13.2(2) *Preliminary processing.* Completed forms shall be returned to the disability retirement benefits officer. If the forms are not complete, they will be returned for completion. The application package shall contain copies of all relevant medical records and the names, addresses, and telephone numbers of all relevant physicians. If medical records are not included, the designated retirement benefits officer shall have the authority to contact the listed physicians for copies of the files on the individual and shall request that any applicable files be sent to the medical board. In addition, IPERS may request workers' compensation records, social security records and such other official records as are deemed necessary. The application, including copies of the medical information, shall be forwarded to the medical board for review. All medical records that will be part of a member's permanent file shall be kept in locked locations separate from the member's other retirement records.

13.2(3) *Scheduling of appointments.* Upon receipt and forwarding of the application and sufficient medical records to the medical board, the disability retirement benefits officer shall establish an appointment for the applicant to be seen by the medical board in Iowa City. The member shall be notified by telephone and in writing of the appointment, and shall be given general instructions about where to go for the examinations. The appointment for the examinations shall be no later than 60 days after the completed application, including sufficient medical records, is provided. All examinations must be scheduled and completed on the same date. The member shall also be notified about the procedures to follow for reimbursement of travel expenses and lodging. Fees for physical examinations and medical records costs shall be paid directly by IPERS pursuant to its contractual arrangements with the medical providers required to implement Iowa Code section 97B.50A.

13.2(4) *Medical board examinations.* The medical board, consisting of three physicians from the University of Iowa occupational medicine clinic and other departments as required, shall examine the member and perform the relevant tests and examinations.

The medical board shall submit a letter of recommendation to the system, based on its findings and the job duties supplied in the member's application, whether or not the member is mentally or physically incapacitated from the further performance of the member's duties and whether or not the incapacity is likely to be permanent. "Permanent" means that the mental or physical incapacity is reasonably expected to last more than one year. The medical board's letter of recommendation shall include a recommended schedule for reexaminations to determine the continued existence of the disability in question.

IPERS shall not be liable for any diagnostic testing procedures performed in accordance with Iowa Code section 97B.50A and this rule which are alleged to have resulted in injury to the members being examined.

The medical board shall furnish its determination, test results, and supporting notes to the system no later than ten working days after the date of the examination. The medical board may use electronic signatures in fulfilling its reporting obligations under this rule.

The medical board shall not be required to have regular meetings, but shall be required to meet with IPERS' representatives at reasonable intervals to discuss the implementation of the program and performance review.

13.2(5) *Member and employer comments.* Upon receipt by the system, the medical board's determination regarding the existence or nonexistence of a permanent disability shall be distributed to the member and to the employer for review. The member and the employer may forward to the

system written statements pertaining to the medical board's findings within ten days of transmittal. If relevant medical information not considered in materials previously forwarded to the medical board is contained within such written statements, the system shall submit such information to the medical board for review and comment.

13.2(6) *Fast-track review.* IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer for fast-track review. The CEO or the CEO's designee may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

13.2(7) *Initial administrative determination.* The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 days after a complete file has been returned to IPERS for the initial disability determination.

13.2(8) *General benefits provisions.* Effective July 1, 2000, if an initial disability determination is favorable, benefits shall begin as of the date of the initial disability determination or, if earlier, the member's last day on the payroll, but no more than six months of retroactive benefits are payable, subject to Iowa Code section 97B.50A(13). "Last day on the payroll" shall include any form of authorized leave time, whether paid or unpaid. If a member receives short-term disability benefits from the employer while awaiting a disability determination hereunder, disability benefits will accrue from the date the member's short-term disability payments are discontinued. If an initial favorable determination is appealed, the member shall continue to receive payments pending the outcome of the appeal.

Any member who is awarded disability benefits under Iowa Code section 97B.50A and this rule shall be eligible to elect any of the benefit options available under Iowa Code section 97B.51. All such options shall be the actuarial equivalent of the lifetime monthly benefit provided in Iowa Code section 97B.50A(2) and (3).

The disability benefits established under this subrule shall be eligible for the favorable experience dividends payable under Iowa Code section 97B.49F(2).

If the award of disability benefits is overturned upon appeal, the member may be required to repay the amount already received or, upon retirement, have payments suspended or reduced until the appropriate amount is recovered.

IPERS shall, at the member's written request, precertify a member's medical eligibility through the procedures set forth in subrules 13.2(3) and 13.2(4), provided that IPERS shall have full discretion to request additional medical information and to redetermine the member's medical eligibility if the member chooses not to apply for disability benefits at the time of the precertification. IPERS shall not pay for the costs of more than one such precertification per 12-month period.

13.2(9) *In-service disability determinations.* Subject to the presumptions contained in Iowa Code section 97B.50A in determining whether a member's mental or physical incapacity arises in the actual performance of duty, "duty" shall mean:

a. For special service members other than firefighters, any action that the member, in the member's capacity as a law enforcement officer:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs in the course of controlling or reducing crime or enforcing the criminal law; or

b. For firefighters, any action that the member, in the member's capacity as a firefighter:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs while on the scene of an emergency run (including false alarms) or on the way to or from the scene.

c. A presumption shall exist that a special service member contracted a disease while on active duty only if the disease is defined by Iowa Code section 97B.50A(2)*"c"* as amended by 2010 Iowa Acts, House File 2518, section 31. If a presumption exists, IPERS may, in making its determination as to whether a disability was incurred while the member was on active duty, go forward with evidence to rebut the presumption. IPERS can rebut the presumption when credible evidence exists to the contrary or when the requirements are met in Iowa Code section 97B.50A(2)*"c"* as amended by 2010 Iowa Acts, House File 2518, section 31. Under no circumstances shall the burden of proof shift from the special service member to IPERS.

13.2(10) *Appeal rights.* The member or the employer, or both, may appeal IPERS' initial disability determination. Within 30 days after the notification of IPERS' initial disability determination was mailed, the member shall submit to IPERS' CEO or CEO's designee a notice of appeal in writing setting forth:

a. The name, address, and social security number of the member or employee number of the employer;

b. A reference to the decision from which the appeal is being made;

c. The fact that an appeal from the decision is being made;

d. The grounds upon which the appeal is based;

e. Additional medical or other evidence to support the appeal; and

f. The request that a different decision be made by IPERS.

The system shall conduct an internal review of the initial disability determination, and the CEO or CEO's designee shall notify in writing the party who filed the appeal of IPERS' final disability determination with respect to the appeal. The CEO or CEO's designee may appoint a review committee to make nonbinding recommendations on such appeals. The disability retirement benefits officer, if named to the review committee, shall not vote on any such recommendations, nor shall any members of IPERS' legal staff participate in any capacity other than a nonvoting capacity. Further appeals shall follow the procedures set forth in 495—Chapter 26.

13.2(11) *Notice of abuse of disability benefits.* The system has the obligation and full authority to investigate allegations of abuse of disability benefits. The scope of the investigation to be conducted shall be determined by the system, and may include the ordering of a sub rosa investigation of a disability recipient to verify the facts relating to an alleged abuse. A sub rosa investigation shall only be considered upon receipt and evaluation of an acceptable notice of abuse. The notification must be in writing and include:

a. The informant's name, address, telephone number, and relationship to the disability recipient; and

b. A statement pertaining to the circumstances that prompted the notification, such as activities which the informant believes are inconsistent with the alleged disability.

c. Anonymous calls shall not constitute acceptable notification.

IPERS may employ such investigators and other personnel, in IPERS' sole discretion, as may be deemed necessary. IPERS may also, in its sole discretion, decline to carry out such investigations if more than five years have elapsed since the date of the disability determination.

13.2(12) *Qualification for social security or railroad retirement disability benefits.* Upon qualifying for social security or railroad retirement disability benefits, a special service member may contact the system to have the member's disability benefits calculated under Iowa Code section 97B.50(2). The member and spouse must complete the designated application to stop having benefits calculated under Iowa Code section 97B.50A and to start having benefits calculated under Iowa Code section 97B.50(2). The decision is irrevocable, and must be made within 60 days after the member receives written notification of eligibility for disability benefits from social security or railroad retirement and has commenced receiving such payments.

13.2(13) *Reemployment/income monitoring.* A member who retires under Iowa Code section 97B.50A and this rule shall be required to supply a copy of a complete set of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if such records are not timely provided.

Only wages and self-employment income shall be counted in determining a member's reemployment comparison amount, as adjusted for health care coverage for the member and member's dependents.

For purposes of calculating the income offsets required under Iowa Code section 97B.50A, IPERS shall convert any lump sum workers' compensation award, disability insurance payments, or similar lump sum awards for the same illnesses or injuries to an actuarial equivalent, as determined by IPERS.
[**ARC 8929B**, IAB 7/14/10, effective 6/21/10]

These rules are intended to implement Iowa Code sections 97B.50 and 97B.50A.

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CHAPTER 14
DEATH BENEFITS AND BENEFICIARIES
[Prior to 11/24/04, see 581—Ch 21]

495—14.1(97B) Internal Revenue Code limitations. The death benefits payable under Iowa Code sections 97B.51 and 97B.52 shall not exceed the maximum amount possible under Internal Revenue Code Section 401(a)(9).

To ensure that the limit is not exceeded, a member's combined lump sum death benefit under Iowa Code sections 97B.52(1) and 97B.52(2) shall not exceed 100 times the Option 2 amount that would have been payable to the member at the member's earliest normal retirement age. If a beneficiary of a special service member is eligible for an in-the-line-of-duty death benefit, any reduction required under this rule shall be taken first from a death benefit payable under Iowa Code section 97B.52(1). The "100 times" limit shall apply to active and inactive members. The death benefits payable under this chapter for a period of reemployment for a retired reemployed member who dies during the period of reemployment shall also be subject to the limits described in this rule.

The maximum claims period for IPERS lump sum death benefits shall not exceed the period required under Internal Revenue Code Section 401(a)(9), which may be less than five years for a member who dies after the member's required beginning date, unless the beneficiary is an opposite gender spouse. The claims period for all cases in which the member's death occurs during the same calendar year in which a claim must be filed under this rule shall end April 1 of the year following the year of the member's death.

A member's beneficiary or heir may file a claim for previously forfeited death benefits. Interest, if any, for periods prior to the date of the claim will only be credited through the quarter that the death benefit was required to be forfeited by law. Interest for periods following the quarter of forfeiture will accrue beginning with the quarter that the claim for reinstatement is received by IPERS. For death benefits required to be forfeited in order to satisfy Section 401(a)(9) of the federal Internal Revenue Code, in no event will the forfeiture date precede January 1, 1988. IPERS shall not be liable for any excise taxes imposed by the Internal Revenue Service on reinstated death benefits.

Effective January 14, 2004, all claims for a previously forfeited death benefit shall be processed under the procedure set forth at rule 495—14.13(97B).

The system recognizes the validity of same gender marriages consummated in Iowa on or after April 27, 2009. The Iowa Supreme Court decision recognizing same gender marriages in Iowa specifically states that this recognition does not extend to same gender marriages of other states. The following special rules apply to same gender marriages in Iowa. IPERS shall administer marital property and support orders of same gender spouses married in Iowa on or after April 27, 2009, if the orders otherwise meet the system's minimum requirements for such orders, but shall modify the tax treatment of distributions under such orders as required by the federal laws governing such distributions. IPERS shall adopt such rules and procedures as are deemed necessary to fully implement the provisions of this subrule.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—14.2(97B) Survival into first month of entitlement. When a member who has filed an application for retirement benefits and has survived into the first month of entitlement dies prior to the issuance of the first benefit check, IPERS will pay the death benefit allowed under the retirement option elected by the member in the application for retirement benefits.

495—14.3(97B) Designation of beneficiaries.

14.3(1) *Designation of beneficiaries.* To designate a beneficiary, the member must complete an IPERS designation of beneficiary form, which must be filed with IPERS. The designation of a beneficiary by a retiring member on the application for monthly benefits revokes all prior designation of beneficiary forms. IPERS may consider as valid a designation of beneficiary form filed with the member's employer prior to the death of the member, even if that form was not forwarded to IPERS prior to the member's death. If a retired member is reemployed in covered employment, the most recently filed beneficiary form shall govern the payment of all death benefits for all periods of

employment. Notwithstanding the foregoing sentence, a reemployed IPERS Option 4 or 6 retired member may name someone other than the member's contingent annuitant as beneficiary, but only for lump sum death benefits accrued during the period of reemployment and only if the contingent annuitant has died or has been divorced from the member before the period of reemployment unless a qualified domestic relations order (QDRO) directs otherwise. If a reemployed IPERS Option 4 or 6 retired member dies without filing a new beneficiary form, the death benefits accrued for the period of reemployment shall be paid to the member's contingent annuitant, unless the contingent annuitant has died or been divorced from the member. If the contingent annuitant has been divorced from the member, any portion of the lump sum death benefits awarded in a QDRO shall be paid to the contingent annuitant as alternate payee, and the remainder of the lump sum death benefits shall be paid to the member's estate or, if applicable, to the member's heirs if no estate is probated.

14.3(2) *Change of beneficiary.* The beneficiary may be changed by the member by filing a new designation of beneficiary form with IPERS. The latest dated designation of beneficiary form on file shall determine the identity of the beneficiary. Payment of a refund to a terminated member cancels the designation of beneficiary on file with IPERS.

495—14.4(97B) Applications for death benefits. Before death benefit payments can be made, application in writing must be submitted to IPERS with a copy of the member's death certificate, together with information establishing the claimant's right to payment. A named beneficiary must complete an IPERS application for death benefits based on the deceased member's account. If the claimant's claim is based on dissolution of marriage that revoked the IPERS beneficiary designation, the claim must be processed pursuant to rule 14.16(97B).

495—14.5(97B) Commuted lump sums.

14.5(1) *Designated beneficiary is an estate, trust, church, charity, or similar organization.* Where the designated beneficiary is an estate, trust, church, charity or similar organization, or is a person, such as a trustee, executor, or administrator who has been appointed to receive funds on behalf of such entities, payment of benefits shall be made in a lump sum only.

14.5(2) *Multiple beneficiaries.* Where multiple beneficiaries have been designated by the member, payment, including the payment of the remainder of a series of guaranteed annuity payments, shall be made in a lump sum only. The lump sum payment shall be paid to the multiple beneficiaries in equal shares.

14.5(3) *Guaranteed payments.* Where a member has selected Option 5 and dies before receiving all guaranteed payments, and the member's designated beneficiary also dies before all guaranteed payments are made, any remaining guaranteed payments shall be paid in a commuted lump sum.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10]

495—14.6(97B) Payment of the death benefit when no designation of beneficiary or an invalid designation of beneficiary form is on file. When no designation of beneficiary or an invalid designation of beneficiary form is on file with IPERS, payment shall be made in one of the following ways.

14.6(1) Where the estate is open, payment shall be made to the administrator or executor where said executor or administrator shall be duly appointed and serving under Iowa Code chapter 633 or 635.

14.6(2) Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits, payment will be made to the surviving spouse. The following documents shall be presented as supporting evidence:

a. Copy of the will, if any;

b. Copy of any letters of appointment; and

c. Copy of the court order closing the estate and discharging the executor or administrator.

14.6(3) Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits and there is no surviving spouse, payment will be made to the heirs-at-law as determined by the intestacy laws of the state of Iowa.

14.6(4) Where a trustee has been named as designated beneficiary and is not willing to accept the death benefit or otherwise serve as trustee, IPERS may apply but is not required to apply to the applicable district court for an order to distribute the funds to the clerk of court on behalf of the beneficiaries of the member's trust. Upon the issuance of an order and the giving of such notice as the court prescribes, IPERS may deposit the death benefit with the clerk of court for distribution. IPERS shall be discharged from all liability upon deposit with the clerk of court.

495—14.7(97B) Waiver of beneficiary rights. A named beneficiary of a deceased member may waive current and future rights to payments to which the beneficiary would have been entitled. The waiver of the rights shall occur prior to the receipt of a payment from IPERS to the beneficiary. The waiver of rights shall be binding and will be executed on a form provided by IPERS. The waiver of rights may be general, in which case payment shall be divided equally among all remaining designated beneficiaries or, if there are none, to the member's estate. The waiver of rights may also expressly be made in favor of one or more of the member's designated beneficiaries or the member's estate. If the waiver of rights operates in favor of the member's estate and no estate is probated or claim made, or if the executor or administrator expressly waives payment to the estate, payment shall be paid to the member's surviving spouse unless there is no surviving spouse or the surviving spouse has waived the surviving spouse's rights. In that case, payment shall be made to the member's heirs excluding any person who waived the right to payment. Any waiver filed by an executor, administrator, or other fiduciary must be accompanied by a release acceptable to IPERS indemnifying IPERS from all liability to beneficiaries, heirs, or other claimants for any waiver executed by an executor, administrator, or other fiduciary.

495—14.8(97B) Beneficiaries under the age of 18. Payment may be made to a conservator if the beneficiary is under the age of 18 and the total dollar amount to be paid by IPERS to a single beneficiary is $25,000 or more. Payment may be made to a custodian if the total dollar amount to be paid by IPERS to a single beneficiary is less than $25,000.

495—14.9(97B) Simultaneous deaths. IPERS will apply the provisions of the Uniform Simultaneous Death Act, Iowa Code sections 633.523 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.10(97B) Felonious deaths. IPERS will apply the provisions of the Felonious Death Act, Iowa Code sections 633.535 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.11(97B) No interest on postretirement death benefits. Interest is only accrued on a member's death benefit if the member dies before the member's first month of entitlement (FME) or, for a retired reemployed member, before the member's reemployment FME, and is only accrued with respect to the retired or retired reemployed member's accumulated contributions account.

495—14.12(97B) Preretirement death benefits.

14.12(1) *Pre-January 1, 1999, deaths.* Where the member dies prior to the first month of entitlement, the death benefit shall include the accumulated contributions of the member plus the product of an amount equal to the highest year of covered wages of the deceased member and the number of years of membership service divided by the "applicable denominator," as provided in Iowa Code section 97B.52(1). The amount payable shall not be less than the amount that would have been payable on the death of the member on June 30, 1984. The calculation of the highest year of covered wages shall use the highest calendar year of covered wages reported to IPERS.

14.12(2) *Post-January 1, 1999, deaths—death benefits under Iowa Code section 97B.52(1).*

a. Definitions.

"Accrued benefit" means the monthly amount that would have been payable to the deceased member under IPERS Option 2 at the member's earliest normal retirement age, based on the member's covered wages and service credits at the date of death. If a deceased member's wage record consists of

a combination of regular and special service credits, the deceased member's earliest normal retirement age shall be determined under the regular or special service benefit formula for which the majority of the deceased member's service credits were reported.

"Beneficiary(ies)" shall, unless the context indicates otherwise, refer to both window period beneficiaries and post-window period beneficiaries.

"Implementation date" means January 1, 2001.

"Nearest age" means a member's or beneficiary's age expressed in whole years, after rounding for partial years of age. Ages shall be rounded down to the nearest whole year if less than six complete months have passed following the month of the member's or beneficiary's last birthday, and shall be rounded up if six complete months or more have passed following the month of the member's or beneficiary's last birthday.

"Post-window period beneficiary" means a beneficiary of a member who dies before the member's first month of entitlement and on or after January 1, 2001.

"Window period beneficiary" means a beneficiary of a member who dies before the member's first month of entitlement during the period January 1, 1999, through December 31, 2000.

b. Any window period beneficiary or post-window period beneficiary may elect to receive the lump sum amount available under Iowa Code section 97B.52(1). Sole beneficiaries may elect, in lieu of the foregoing lump sum amount, to receive a single life annuity that is the actuarial equivalent of such lump sum amount.

A window period beneficiary must repay any prior preretirement death benefit received as follows:

(1) If a window period beneficiary wishes to receive the larger lump sum amount, if any, the system shall pay the difference between the prior death benefit lump sum amount and the new death benefit lump sum amount.

(2) If a sole window period beneficiary wishes to receive a single life annuity under Iowa Code section 97B.52(1), the sole window period beneficiary may either:

1. Annuitize the difference between the previously paid lump sum amount and the new larger lump sum amount, if any; or

2. Annuitize the full amount of the largest of the lump sum amounts available under the revised statute, but must repay the full amount of the previously paid lump sum amount.

(3) To the extent possible, repayment costs shall be recovered from retroactive monthly payments, if any, and the balance shall be offset against current and future monthly payments until the system is repaid in full.

c. A claim for a single life annuity under this subrule must be filed as follows:

(1) A sole window period beneficiary must file a claim for a single life annuity within 12 months of the implementation date.

(2) A sole post-window period beneficiary must file a claim for a single life annuity within 12 months of the member's death.

(3) A beneficiary who is a surviving spouse must file a claim for a single life annuity within the period specified in subparagraph (1) or (2), as applicable, or by the date that the member would have attained the age of 70½, whichever period is longer.

d. Elections to receive the lump sum amount or single life annuity available under Iowa Code section 97B.52(1) and this subrule shall be irrevocable once the first payment is made. Election shall be irrevocable as of the date the first paycheck is issued, or would have been issued but for the fact that the payment is being offset against a prior preretirement death benefit payment.

e. No further benefits will be payable following the death of any beneficiary who qualifies and elects to receive the single life annuity provided under this subrule.

f. The provisions of this subrule shall not apply to members who die before January 1, 1999.

g. Procedures and assumptions to be used in calculating the lump sum present value of a member's accrued benefit are as follows:

(1) IPERS shall calculate a member's retirement benefit at earliest normal retirement age under IPERS Option 2, based on the member's covered wages and service credits at the date of death, and the retirement benefit formula in effect in the month following the date of death.

(2) For purposes of determining the "member date of death annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the member's nearest age at the member's date of death.

(3) For purposes of determining the "member unreduced retirement annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the member's nearest age at the member's earliest normal retirement date. If a member had already attained the member's earliest normal retirement date, IPERS shall assume that "age" means the member's nearest age at the date of death.

h. Procedures and assumptions for converting the lump sum present value of a deceased member's preretirement death benefit to a single life annuity are as follows:

(1) For purposes of determining the "age of beneficiary annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the beneficiary's nearest age as of the beneficiary's first month of entitlement.

(2) A beneficiary's first month of entitlement is the month after the date of the member's death.

(3) Effective for claims filed after June 30, 2004, no retroactive payments of the single life annuity shall be made under this subrule.

(4) Effective for claims filed after June 30, 2004, the beneficiary whose single life annuity is less than $600 per year shall be able to receive only the lump sum payment under this rule.

i. Eligibility for favorable experience dividend (FED) payments. Any sole beneficiary who is eligible for and elects to receive a single life annuity under this subrule shall also qualify for the dividend payments authorized under rule 495—15.2(97B), subject to the requirements of that rule.

j. Retired reemployed members and aged 70 members who retire without terminating employment. Preretirement death benefits for retired reemployed members and aged 70 members who retire without terminating employment shall be calculated as follows:

(1) For beneficiaries of such members who elect IPERS Option 4 or 6 at retirement, IPERS shall recompute (for retired reemployed members) or recalculate/recompute (for aged 70 members who retired without terminating employment) the member's monthly benefits as though the member had elected to terminate employment as of the date of death, to have the member's benefits adjusted for postretirement wages, and then lived into the recomputation or recalculation/recomputation (as applicable) first month of entitlement.

(2) The recomputation provided under subparagraph (1) shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of reemployment, and is subject to the limitations of Iowa Code sections 97B.48A, 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. The recalculation/recomputations provided under subparagraph (1) shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of employment after the initial retirement, and is subject to the limitations of Iowa Code sections 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. In all other cases, preretirement death benefits under this subparagraph shall be equal to the lump sum amount equal to the accumulated employee and accumulated employer contributions.

(3) Beneficiaries of members who had elected IPERS Option 4 or 6 may also elect to receive the accumulated employer and accumulated employee contributions described in subparagraph 14.12(2)*"j"*(2), in lieu of the increased monthly annuity amount. Notwithstanding subparagraph (2) above, if the member elected IPERS Option 5 at retirement, the lump sum amount payable under this paragraph shall be the greater of the applicable commuted lump sum or the accumulated employee and accumulated employer contributions.

k. Inactive members with less than 16 quarters of service credit. For deaths occurring after June 30, 2004, preretirement death benefits shall be provided solely under Iowa Code section 97B.52(1)*"a,"* and shall only be payable in lump sum amounts for inactive members who have less than 16 quarters of service credit. For purposes of this paragraph, an inactive member is a member as defined under Iowa Code section 97B.1A(12).

495—14.13(97B) Payment procedures for heirs that cannot be located.

14.13(1) *Order of priority.* If a death benefit cannot be paid because heirs cannot be located, IPERS will pay a death benefit to the member's heirs according to the following procedure.

a. Children. If there is no surviving spouse, but at least one child survives, the death benefit shall be divided equally among the member's children. If there are living and deceased children, the shares that would have been payable to deceased children shall be payable in equal shares to the surviving children of each such deceased child.

b. Grandchildren. If neither the spouse nor children survive, but at least one grandchild survives, the death benefit shall be divided equally among the member's grandchildren. If there are living and deceased grandchildren, the shares that would have been payable to any deceased grandchild shall be payable in equal shares to the surviving children of such deceased grandchild.

c. Parent(s). If there is no surviving spouse, child, or grandchild, but at least one parent survives, the death benefit shall be divided equally between the member's parents.

d. Siblings. If there is no surviving spouse, child, grandchild, or parent, but at least one sibling survives, the death benefit shall be divided equally among the member's siblings. If there are living and deceased siblings, the shares that would have been payable to any deceased sibling shall be payable in equal shares to the surviving children of such deceased siblings.

e. Nephew(s) and niece(s). If no one from the above-mentioned groups survives, but there is at least one surviving niece or nephew, the death benefit shall be divided equally among the member's surviving nieces and nephews.

f. Estate. If someone other than a member of one of the groups listed above claims the member's death benefit, an estate must be opened and the death benefit shall only be payable to the administrator of that estate.

14.13(2) *Procedures for initial distribution for identified heirs.* IPERS shall distribute the death benefit to the heirs making a claim for such benefit in descending order listed in 14.13(1)*"a"* to *"f."* A claimant shall be required to submit an affidavit suitable to IPERS that verifies the claimant's share or, to the best of the claimant's knowledge, that there are no other surviving persons from the claimant's group and that there are no living persons in any lower-numbered group that would have a higher priority claim to the death benefit. IPERS shall have no responsibility to determine or search out the member's heirs at law, nor shall IPERS incur any liability for relying on a claimant's affidavits in paying the death benefit hereunder.

14.13(3) *Procedures for final distribution to heirs who have filed claims.* If a claimant has identified other persons in the claimant's group who would be entitled to a share of the member's death benefit, but such persons have not filed a claim within five years after the member's death, or by the date required under IRC Section 401(a)(9) if earlier, the remainder of the member's death benefit shall be paid in pro-rata shares to the claimants who were previously paid a share of the death benefit. In order to comply with the applicable IRS limitations, the final payments under this subrule shall be made by December 31 of the fifth year that begins after the member's date of death, or by December 31 of the year that distribution is required under IRC Section 401(a)(9), if earlier. The sole recourse of any claimant who is a member of a group receiving payments hereunder or of any lower-numbered group that should have received all of such payments shall be against the claimants of the group that received death benefit payments.

495—14.14(97B) Procedures for deaths of certain voluntary emergency services personnel occurring in the line of duty. Effective July 1, 2006, for a member who dies while performing the functions of a voluntary emergency services provider as described under Iowa Code section 85.61 or 147A.1, benefits for deaths occurring in the line of duty shall be paid pursuant to Iowa Code section 100B.31.

495—14.15(97B) Rollovers by nonspouse beneficiaries. Effective January 1, 2007, nonspouse beneficiaries shall be permitted to request a direct rollover of such beneficiaries' death benefit payments to traditional IRA accounts established in accordance with Section 829 of the Pension Protection Act

of 2006 and IRS Notice 2007-7. IPERS shall determine the amount eligible for direct rollover under IRC Section 401(a)(9), if any, and the procedural requirements for requesting such rollovers. It shall be the beneficiaries' responsibility to determine that the recipient IRAs meet the structural and operational requirements of Section 829 and Notice 2007-7. IPERS shall bear no responsibility for rollovers to IRA accounts that fail to meet such requirements.

Effective January 1, 2008, IPERS will also allow rollovers under this rule to Roth IRA accounts established in accordance with the structural and operational requirements of Section 829 and Notice 2007-7.

495—14.16(97B) Required minimum distribution (RMD) basic calculation.

14.16(1) The RMD for a member who retired under an option with a lump sum death benefit and died after the member's required beginning date (RBD) is calculated as follows:

a. Step 1. Determine the number of payments remaining for the calendar year in which the member died. The current month's payment is not used in this calculation.

b. Step 2. Multiply the number of remaining payments determined in Step 1 by the gross amount of the member's last monthly payment to get the RMD amount. If the lump sum death benefit is less than the RMD, then the RMD is the lump sum death benefit amount.

c. Step 3. Determine the total non-RMD amount by subtracting the RMD as determined in Step 2 from the lump sum death benefit.

d. The eligible rollover amount is the total non-RMD amount as determined in Step 3.

14.16(2) In order to allocate nontaxable amounts between RMD and non-RMD, the calculation is performed as follows:

a. Nontaxable amounts are allocated first to the RMD portion of the lump sum death benefit.

b. If the nontaxable amounts are greater than the RMD amount, the remaining nontaxable amounts are allocated to the non-RMD portion of the lump sum amount.

c. If the nontaxable amounts are less than the RMD amount, the remaining portion of the RMD amount is composed of taxable amounts.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10]

495—14.17(97B) Beneficiary revocation pursuant to Iowa Code section 598.20B, dissolution of marriage. IPERS is not liable for the payment of death benefits to a beneficiary pursuant to a beneficiary designation that has been revoked or reinstated by a divorce, annulment, or remarriage before IPERS receives the written notice set forth in subrule 14.17(1). Furthermore, IPERS shall only be liable for payments made after receipt of such written notice if the written notice is received at least ten calendar days prior to the payment.

14.17(1) *Form of notice.* The written notice shall include the following information:

a. The name of the deceased member,

b. The name of the person(s) whose entitlement to IPERS death benefits is being challenged,

c. The name, address, and telephone number of the person(s) asserting an interest,

d. A statement that the decedent's divorce, annulment, or remarriage revoked the entitlement of the person(s) whose status is being challenged to the IPERS death benefits in question, and

e. A copy of the divorce decree upon which the claim is based.

In addition to the above information, if the person whose entitlement is being challenged is not the former spouse, the written notice must indicate that the person was related to the former spouse, but not the member, by blood, adoption or affinity, and state the nature of the relationship.

14.17(2) *Delivery of notice.* Written notice under this rule must be addressed to IPERS General Counsel and mailed to IPERS by registered mail or served upon IPERS in the same manner as a summons in a civil action.

14.17(3) *Administration.* Upon receipt of written notice that meets the requirements of subrules 14.17(1) and 14.17(2):

a. IPERS shall review the deceased member's account and determine if there are moneys left to be distributed from the account.

b. IPERS shall pay the amounts owed, if any, to the probate court having jurisdiction over the decedent's estate, if the deceased member has an open estate.

c. IPERS shall pay the amounts owed, if any, to the probate court that had or would have had jurisdiction over the decedent's estate, if the deceased member's estate is closed or an estate was not opened.

d. As IPERS makes applicable payments, a copy of the written notice received by IPERS shall be filed with the probate court.

If the probate court charges a filing fee for the deposit of amounts payable hereunder, IPERS shall deduct such filing fees and other court costs from the amounts payable prior to transfer. The probate court shall hold the funds and, upon its determination, shall order disbursement or transfer in accordance with the determination. Additional filing fees and court costs, if any, shall be charged upon disbursement either to the recipient or against the funds on deposit with the probate court, in the discretion of the court.

14.17(4) *Release of claims.* Payments made to a probate court under this rule shall discharge IPERS from all claims by all persons for the value of amounts paid the court.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 8929B**, IAB 7/14/10, effective 6/21/10]

495—14.18(97B) Special rules for tax treatment of distributions to same gender spouse and same gender former spouse alternate payees.

14.18(1) A beneficiary who is a same gender spouse or a same gender former spouse alternate payee shall be permitted to request direct rollovers of such beneficiary death benefit payments in the same manner as provided for a nonspouse beneficiary.

14.18(2) Effective April 27, 2009, the term "eligible person" under Iowa Code section 97B.53B includes a same gender surviving spouse or same gender former spouse alternate payee, both of whom are subject to the limits specified in Iowa Code section 97B.53B(1)*"b"*(4).

14.18(3) The term "eligible rollover distribution" does not include any lump sum distribution of benefits to a same gender spouse or same gender former spouse alternate payee, excluding death benefit distributions.

14.18(4) The system shall have the authority to do whatever is necessary in its sole discretion to ensure that federal taxation of benefits paid to same gender spouses and same gender former spouses meets the requirements of the federal laws governing such distributions.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 8929B**, IAB 7/14/10, effective 6/21/10]

These rules are intended to implement Iowa Code sections 97B.1A(8), 97B.1A(18), 97B.1A(19), 97B.34, 97B.34A, 97B.44, 97B.52 and 97B.53B and 2000 Iowa Acts, chapter 1077, section 75.

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CHAPTER 16
DOMESTIC RELATIONS ORDERS AND OTHER ASSIGNMENTS
[Prior to 11/24/04, see 581—Ch 21]

495—16.1(97B) Garnishments and income withholding orders.

16.1(1) For the limited purposes of this rule, the term "member" includes IPERS members, beneficiaries, contingent annuitants and any other third-party payees to whom IPERS is paying a monthly benefit or a lump sum distribution.

16.1(2) A member's right to any payment from IPERS is not transferable or assignable and is not subject to execution, levy, attachment, garnishment, or other legal process, including bankruptcy or insolvency law, except for the purpose of enforcing child, spousal, or medical support.

16.1(3) Only members receiving payment from IPERS, including monthly benefits and lump sum distributions, may be subject to garnishment, attachment, or execution against funds that are payable. Such garnishment, attachment, or execution is not valid and enforceable for members who have not applied for and have not been approved to receive funds from IPERS.

16.1(4) Upon receipt of an income withholding order issued by the Iowa department of human services or a court, IPERS shall send a copy of the withholding order to the member. If a garnishment has been issued by a court, the party pursuing the garnishment shall send a notice pursuant to Iowa law to the member against whom the garnishment is issued.

16.1(5) IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the initial withholding order until instructed by the court or the Iowa department of human services issuing the order to amend or cease payment. IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the garnishment until the garnishment expires or is released.

16.1(6) Funds withheld or garnished are taxable to the member. IPERS may assess a fee of $2 per payment in accordance with Iowa Code section 252D.18A(2). The fee will be deducted from the gross amount, less federal and state income tax, before a distribution is divided.

16.1(7) A garnishment, attachment or execution may not be levied upon funds which are already the subject of a levy, including a levy placed upon funds by the United States Internal Revenue Service, unless the requirements of IRC Section 6334(a)(8) are met. Multiple garnishments, attachments and executions are allowed as long as the amount levied upon does not exceed the limitations prescribed in 15 U.S.C. Section 1673(b).

16.1(8) IPERS may release information relating to entitlement to funds to a court or to the Iowa department of human services prior to receipt of a valid garnishment, attachment, execution, or income withholding order when presented with a written request stating the information requested and reasons for the request. This request must be signed by a magistrate, judge, or child support recovery unit director or the director's designee, including an attorney representing the Iowa department of human services. In addition, IPERS may release information to the Iowa department of human services through automated matches.

495—16.2(97B) Domestic relations orders. This rule shall apply only to marital property orders. All support orders shall continue to be administered under rule 495—16.1(97B).

16.2(1) *Definitions.*

"Administrable domestic relations order" or *"ADRO"* means a domestic relations order that divides the marital property of same gender spouses, assigns to same gender alternate payees the right to receive all or a portion of the benefits payable with respect to a member under IPERS, and meets the requirements of this rule.

"Alternate payee" means a spouse or former spouse, regardless of gender, of a member who is recognized by a domestic relations order as having a right to receive all or a portion of the benefits payable by IPERS with respect to such member.

"Benefits" means, for purposes of this rule and depending on the context, a refund, monthly allowance (including monthly allowance paid as an actuarial equivalent (AE)), or death benefit payable with respect to a member covered under IPERS. "Benefits" does not include dividends payable under

Iowa Code section 97B.49 or other cost-of-living increases unless specifically provided for in a QDRO or an ADRO.

"Domestic relations order" means any judgment, decree, or order which relates to the provision of marital property rights to a spouse or former spouse, regardless of gender, of a member and is made pursuant to the domestic relations laws of a state.

"Member" means, for purposes of this rule, IPERS members, beneficiaries, and contingent annuitants.

"Qualified domestic relations order" or *"QDRO"* means a domestic relations order that divides the marital property of opposite gender spouses and assigns to an opposite gender alternate payee the right to receive all or a portion of the benefits payable with respect to a member under IPERS and meets the requirements of this rule.

"Same gender spouse" or *"same gender former spouse"* means a spouse or former spouse who is the same sex as the member.

"Successor alternate payee" means a person or persons named in a domestic relations order to receive the amounts payable to the alternate payee under the QDRO or ADRO if the alternate payee dies before the member. Successor alternate payees must be named individuals, not a class of individuals, a trust or an estate.

"Trigger event" means a distribution or series of distributions of benefits made with respect to a member.

16.2(2) *Requirements.*

a. Mandatory provisions. A domestic relations order is a QDRO or an ADRO if such order:

(1) Clearly specifies the member's name and last-known mailing address, member identification number or social security number, and the names and last-known mailing addresses and social security numbers of alternate payees. This information shall be provided to IPERS in a cover letter or a court's Confidential Information Form;

(2) Clearly specifies a fixed dollar amount or a percentage, but not both, of the member's benefits to be paid by IPERS to the alternate payee or the manner in which the fixed dollar amount or percentage is to be determined, provided that no such method shall require IPERS to perform present value calculations of the member's accrued benefit;

(3) Clearly specifies the period to which such order applies, including whether benefits cease upon the death or remarriage of the alternate payee;

(4) Clearly specifies that the order applies to IPERS;

(5) Clearly specifies that the order is for purposes of making a property division; and

(6) Is clearly signed by the judge and filed with the clerk of court. IPERS will consider an order duly signed if it carries an original signature, a stamp bearing the judge's signature, or is conformed in accordance with local court rules.

b. Prohibited provisions. A domestic relations order is not a QDRO or an ADRO if such order:

(1) Requires IPERS to provide any type or form of benefit or any option not otherwise provided under Iowa Code chapter 97B;

(2) Requires IPERS to provide increased benefits determined on the basis of actuarial value;

(3) Requires the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined by IPERS to be a QDRO or an ADRO;

(4) Requires any action by IPERS that is contrary to its governing statutes or plan provisions;

(5) Awards any future benefit increases that are provided by the legislature, except as provided in subparagraph 16.2(2)*"c"*(2); or

(6) Requires the payment of benefits to an alternate payee prior to a trigger event.

c. Permitted provisions. A QDRO or an ADRO may also:

(1) If a trigger event has not occurred as of the date the order is received by IPERS, name an alternate payee as a designated beneficiary or contingent annuitant, require the payment of benefits under a particular benefit option, or both;

(2) Specify that the alternate payee shall be entitled to a fixed dollar amount or percentage of dividend payments, or cost-of-living increase or any other postretirement benefit increase to the member (all known as dividend payments), as follows:

1. If the court order awards a fixed dollar amount of benefits to the alternate payee, the dollar amount of dividend payments to be added or method for determining said dollar amount shall be stated in the court order or an award of a share of dividend payments shall be given no effect; and

2. If the court order awards a specified percentage of benefits to the alternate payee, IPERS shall add dividends to the alternate payee's share of the retirement allowance as necessary to keep the alternate payee's share of payments at the percentage specified in the court order;

(3) Bar a vested member from requesting a refund of the member's accumulated contributions without the alternate payee's written consent;

(4) Allow benefits to be paid to an alternate payee based on a period of reemployment for a retired member; and

(5) Name a successor alternate payee to receive the amounts that would have been payable to the member's spouse or former spouse under the order, if the alternate payee dies before the member. The designation of a successor alternate payee in an order shall be void and be given no effect if IPERS does not receive confirmation of the successor's name, social security number, and last-known mailing address in a cover letter or in a copy of the court's confidential information form. A QDRO or an ADRO that lists a series of default successor alternate payees by class or permits a successor alternate payee to designate additional successor alternate payees is not permitted and will be rejected. Once a QDRO or an ADRO is accepted by IPERS for administration, in order to change the designation of successor alternate payees, an amended order is required.

16.2(3) *Administrative provisions.*

a. Payment to an alternate payee shall be made in a like manner and at the same time that payment is made to the member. Payment to the alternate payee shall be in a lump sum if benefits are paid in a lump sum distribution or as monthly payments if a retirement option is in effect. A member shall not be able to receive an actuarial equivalent (AE) under Iowa Code section 97B.48(1) unless the total benefit payable with respect to that member meets the applicable requirements. All divisions of benefits shall be based on the gross amount of monthly or lump sum benefits payable. Federal and state income taxes shall be deducted from the member's and alternate payee's respective shares and reported under their respective federal tax identification numbers. Unrecovered basis shall be allocated on a pro rata basis to the member and alternate payee.

b. The alternate payee shall not be entitled to any share of the member's death benefits except to the extent such entitlement is recognized in a QDRO or an ADRO or in a beneficiary designation filed subsequent to the dissolution.

c. If a QDRO or an ADRO directs the member to name the alternate payee under the order as a designated beneficiary, and the member fails to do so, the provisions of the QDRO or ADRO awarding the alternate payee a share of the member's death benefit shall be deemed, except as revoked or modified in a subsequent QDRO or ADRO, to operate as a beneficiary designation, and shall be given first priority by IPERS in the determination and payment of such member's death benefits. Death benefits remaining after payments required by the QDRO or ADRO, to the extent possible, shall then be made according to the terms of the member's most recent beneficiary designation.

d. If an alternate payee has been awarded a share of the member's benefits and dies before the member, the entire account value shall be restored to the member unless otherwise specified in the order and in the manner required under this rule.

e. An alternate payee shall not receive a share of dividends or other cost-of-living increases, unless so provided in a QDRO or an ADRO.

f. The CEO, or CEO's designee, shall have exclusive authority to determine whether a domestic relations order is a QDRO or an ADRO. A final determination by the CEO, or CEO's designee, may be appealed in the same manner as any other final agency determination under Iowa Code chapter 97B.

g. A person who attempts to make IPERS a party to a domestic relations action in order to determine an alternate payee's right to receive a portion of the benefits payable to a member shall be liable to IPERS for its costs and attorney's fees.

h. A domestic relations order shall not become effective until it is approved by IPERS. If a member is receiving a retirement allowance at the time a domestic relations order is received by the system, the order shall be effective only with respect to payments made after the order is determined to be a QDRO or an ADRO. If distributions have already begun at the time that an order is determined by IPERS to be a QDRO or an ADRO, the order shall be deemed to be the alternate payee's application to begin receiving payments under the QDRO or ADRO. Payment to the alternate payee will be paid for the month the order is accepted by IPERS. If the member is not receiving a retirement allowance at the time a domestic relations order is approved by IPERS and the member applies for a refund or monthly allowance, or dies, no distributions shall be made until the respective rights of the parties under the domestic relations order are determined by IPERS. If IPERS has placed a hold on the member's account following written or verbal notification from the member, member's spouse, or legal representative of either party of a pending dissolution of marriage, and no further contacts are received from either party or their representatives within the following one-year period, IPERS shall release the hold.

i. IPERS and its staff shall have no liability for making or withholding payments in accordance with the provisions of this rule.

j. IPERS has no duty or responsibility to search for alternate payees. Alternate payees must notify IPERS of any change in their mailing addresses. IPERS shall contact the alternate payee in writing, notifying the alternate payee that an application for a distribution has been requested by the member. IPERS shall send the alternate payee an application to be completed and returned to IPERS. The written notice shall inform the alternate payee that if the alternate payee does not return the application to IPERS within 60 days after the materials are mailed by IPERS, the amounts otherwise payable to the alternate payee shall be paid to the member or the member's beneficiary(ies) until a valid application is received and accepted by IPERS. IPERS shall have no liability to the alternate payee with respect to payment of such amounts.

k. If a QDRO or an ADRO requires the member to select an option with joint and survivor provisions (Option 4 or 6) and name the alternate payee as contingent annuitant, acceptable birth proof for the contingent annuitant pursuant to 495—subrule 11.1(2) shall be provided to IPERS prior to the order being approved by IPERS.

l. For both lump sum and monthly payments, the alternate payee's tax withholding and rollover elections, if eligible, must be received before the first or current month's benefit is certified for payment or IPERS will use the applicable default tax withholding elections.

m. If an order that is determined to be a QDRO or an ADRO divides a member's account using a service factor formula and the member's IPERS benefits are based on a number of quarters less than the member's total covered quarters, notwithstanding any terms of the order to the contrary, IPERS shall limit the number of quarters used in the numerator and the denominator of the service fraction to the number of quarters actually used in the calculation of IPERS benefits.

n. Service credit that is purchased during the period when the member is married to the alternate payee shall be added to the numerator and the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Service credit that is purchased during a period when the member is not married to the alternate payee shall only be added to the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Under no circumstances shall the number of quarters in the denominator be more than the number of quarters used to calculate the member's benefit.

o. The parties or their attorneys in a dissolution action involving an IPERS member shall decide between themselves which attorney will submit a proposed domestic relations order to IPERS for review. IPERS shall not review a proposed order that has not been approved as to form by both parties or their counsel. A rejection under this paragraph shall not preclude IPERS from placing a hold on a member's account until the status of a proposed order as a QDRO or an ADRO is resolved.

p. If a domestic relations order has been determined by the system to be an ADRO, before the system will accept the ADRO for current or deferred administration, the alternate payee under that final order shall be required to complete any forms required by IPERS for purposes of determining the proper tax treatment of current or future distributions to that alternate payee in accordance with federal laws governing such distributions.

q. If a member with an IPERS-approved QDRO or ADRO is receiving a distribution according to a qualified benefits arrangement (QBA), the alternate payee shall share in the distribution to the member unless the order specifically states otherwise.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 8929B**, IAB 7/14/10, effective 6/21/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.15, 97B.25, 97B.38 and 97B.39.

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[Filed Emergency ARC 8929B, IAB 7/14/10, effective 6/21/10]

CHAPTER 1
ORGANIZATION

[Prior to 4/18/90, Public Defense Department[650], Ch 5]
[Prior to 5/12/93, Disaster Services Division[607], Ch 1]

605—1.1(29C) Description. The homeland security and emergency management division is a division within the department of public defense.

1.1(1) *Director.* The adjutant general, as the director of the department of public defense under the direction and control of the governor, shall have supervisory direction and control of the homeland security and emergency management division and shall be responsible to the governor for the carrying out of the provisions of Iowa Code chapter 29C. In the event of disaster beyond local control, the adjutant general may assume direct operational control over all or any part of the emergency management functions within this state.

1.1(2) *Administrator.* The homeland security and emergency management division shall be under the management of an administrator appointed by the governor. The administrator shall be vested with the authority to administer homeland security and emergency management affairs in this state and shall be responsible for preparing and executing the homeland security and emergency management programs of this state subject to the direction of the adjutant general. The administrator, upon the direction of the governor and supervisory control of the director of the department of public defense, shall: prepare a comprehensive plan and emergency management program for homeland security, disaster preparedness, response, mitigation, recovery, emergency operation, and emergency resource management of this state; make such studies and surveys of the industries, resources and facilities in this state as may be necessary to ascertain the capabilities of the state for disaster recovery, disaster planning and operations, and emergency resource management, and to plan for the most efficient emergency use thereof; provide technical assistance to any local emergency management commission or joint commission requiring such assistance in the development of an emergency management program; implement planning and training for emergency response teams as mandated by the federal government under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 as amended by the Superfund Amendments and Reauthorization Act of 1986 42 U.S.C.§ 9601 et seq.; the administrator, with the approval of the governor and upon recommendation of the adjutant general, may employ a deputy administrator and such technical, clerical, stenographic and other personnel and make such expenditures within the appropriation or from other funds made available to the department of public defense for purposes of emergency management, as may be necessary to administer the purposes of Iowa Code chapters 29C, 30, and 34A.

[**ARC 8932B**, IAB 7/14/10, effective 8/18/10]

605—1.2(29C) Definitions. The following definitions are applicable to the homeland security and emergency management division:

"Administrator" means the administrator of the homeland security and emergency management division of the department of public defense.

"Comprehensive countywide emergency operations plan" means documents which describe the actions to be taken to lessen the effects of, prepare for, respond to and recover from a disaster by county and city governments, quasi-government agencies, and private organizations which have emergency operations responsibility. The plan is multihazard in scope (covers all hazards for the county) and provides for a coordinated effort. It references authority, assigns functional responsibilities, provides for direction and control, and the effective use of resources.

"Disaster" means human-caused, technological or natural occurrences, such as fire, flood, drought, earthquake, tornado, windstorm, hazardous substance or nuclear power plant accident or incident, which threaten the public peace, health and safety of the people or which damage or destroy public or private property. The term includes terrorism, enemy attack, sabotage, or other hostile action from without the state.

"Division" means the homeland security and emergency management division of the department of public defense.

"Emergency" means a sudden, generally unexpected occurrence or set of circumstances demanding immediate action to protect life or property. Such actions are normally handled in a routine manner by law enforcement, fire protection, public works, utilities, and emergency medical services.

"Emergency management" means lessening the effects of, preparations for, operations during, and recovery from natural, technological or human-caused disasters. These actions are broad in scope and include, but are not limited to: disaster plans, mitigation, preparedness, response, warning, emergency operations, training, exercising, research, rehabilitation, and recovery activities.

"Emergency management performance grant program" means a program by which federal funds are utilized to pay no more than 50 percent of the salaries, benefits, travel, and office expenses incurred in the administration of the state and local emergency management program.

"Homeland security" means the detection, prevention, preemption, and deterrence of and protection from attacks targeted at state territory, population, and infrastructure.

"Joint commissions" means two or more local emergency management commissions acting as a joint commission for the coordination and administration of emergency management.

"Local commission" means the local emergency management commission.

"Mitigation" means any action taken to reduce or eliminate the long-term risk to human life and property from hazards. Examples of mitigation activities include building codes, land use management, floodplain management, building of protective structures such as flood walls, public education, research, risk mapping, safety codes, and statutes and ordinances.

"Preparedness" means any activity taken in advance of an emergency or disaster that improves emergency readiness posture and develops or expands operational capabilities. Examples of preparedness activities include, but are not limited to, continuity of government, emergency alert and warning systems, emergency communications, emergency operations centers, comprehensive countywide emergency operations plans, emergency public information materials, exercise of plans and systems, hazard analysis, mutual aid agreements, resource management, and the training and equipping of personnel.

"Recovery" means short-term activity to return vital life support systems to minimum operating standards and long-term activity designed to return the affected people and areas to their predisaster conditions. Examples of recovery activity are crisis counseling, damage assessment, debris clearance, decontamination, disaster insurance payments, disaster loans and grants, disaster unemployment assistance, public information, community outreach, temporary housing, and reconstruction.

"Response" means any action taken immediately before, during, or directly after an emergency or disaster occurs, which is intended to save lives, minimize injuries, lessen property and environmental damage and enhance the effectiveness of recovery. Examples of response activity include rendering of assistance by emergency responders, activation of the emergency operations center, emergency alert system activation, emergency instructions to the public, emergency plan implementation, public official alerting, evacuation, sheltering of victims, search and rescue, resource mobilization, and warning system activation.

[**ARC 8932B**, IAB 7/14/10, effective 8/18/10]

These rules are intended to implement Iowa Code chapters 29C, 30 and 34A.

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CHAPTER 2
PETITIONS FOR RULE MAKING

[Prior to 5/12/93, Disaster Services Division[607], Ch 2]

605—2.1(17A) Petition for rule making. Any person or agency may file a petition for rule making with the division at the Homeland Security and Emergency Management Division, 7105 NW 70th Avenue, Camp Dodge Building W4, Johnston, Iowa 50131. A petition is deemed filed when it is received by that office. The division must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the division an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

EMERGENCY MANAGEMENT DIVISION

Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	PETITION FOR RULE MAKING

The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the division's authority to take the action urged or to the desirability of that action.
3. A brief summary of the petitioner's arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by or interested in, the proposed action which is the subject of the petition.
6. Any request by petitioner for a meeting provided by rule 2.4(17A).

2.1(1) The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

2.1(2) The homeland security and emergency management division may deny a petition because it does not substantially conform to the required form.

[**ARC 8933B**, IAB 7/14/10, effective 8/18/10]

605—2.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The homeland security and emergency management division may request a brief from the petitioner or from any other person concerning the substance of the petition.

[**ARC 8933B**, IAB 7/14/10, effective 8/18/10]

605—2.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to the Administrator, Homeland Security and Emergency Management Division, 7105 NW 70th Avenue, Camp Dodge Building W4, Johnston, Iowa 50131.

[**ARC 8933B**, IAB 7/14/10, effective 8/18/10]

605—2.4(17A) Consideration.

2.4(1) Within 14 days after the filing of a petition, the division must submit a copy of the petition and any accompanying brief to the administrative rules coordinator and to the administrative rules review committee. Upon request by petitioner in the petition, the homeland security and emergency management division must schedule a brief and informal meeting between the petitioner and the division, a member of the division, or a member of the staff of the division to discuss the petition. The homeland security and emergency management division may request the petitioner to submit

additional information or argument concerning the petition. The division may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the homeland security and emergency management division by any person.

2.4(2) Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the homeland security and emergency management division must, in writing, deny the petition and notify petitioner of its action and the specific grounds for the denial, or grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed notified of the denial or grant of the petition on the date when the division mails or delivers the required notification to petitioner.

2.4(3) Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the division's rejection of the petition.

[**ARC 8933B**, IAB 7/14/10, effective 8/18/10]

These rules are intended to implement Iowa Code chapter 17A.

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PUBLIC SAFETY DEPARTMENT[661]

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CHAPTER 11
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[Rules 11.1 to 11.7 appeared as 4.3 prior to 6/27/79]
[Prior to 4/20/88, see Public Safety Department[680] Ch 11]

Rescinded IAB 7/14/10, effective 9/1/10

CHAPTER 12
CRIMINALISTICS LABORATORY

[Rules 12.1 to 12.11 appeared as 4.5 prior to 6/27/79]
[Prior to 4/20/88, see Public Safety Department[680] Ch 12]

Rescinded IAB 11/22/06, effective 1/1/07. See 661—Chapter 150.

CHAPTER 16
STATE BUILDING CODE—FACTORY-BUILT STRUCTURES

[Transferred from O.P.P., ch 5, See IAB 7/6/83]
[Prior to 4/20/88, see Public Safety Department[680] Ch 16]

661—16.1 to **16.500** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapters 300 and 301.

661—16.501 to **16.609** Reserved.

PART 1—MODULAR FACTORY-BUILT STRUCTURES

661—16.610(103A) "Modular factory-built structures." Division VI, Part 1, contains the rules and regulations which are to apply to all factory-built structures which are not specifically included in Part 2 of this division.

16.610(1) *Authority to promulgate rules.* Provisions contained within all sections of Part 1 are authorized under Iowa Code section 103A.9.

16.610(2) *Scope and applicability.* The provisions contained within Part 1 shall apply to the following:

a. Plan evaluation, manufacture, inspection, and installation of "modular factory-built structures," of closed-type construction and of open-type construction for those manufacturers who have by option chosen to have their building component, assembly or system considered to be closed construction.

b. Approval by the commissioner or the commissioner's designated representative of an organization or person referred to as a third-party agent, or independent inspection agency.

c. All "modular factory-built structures" manufactured for installation in Iowa after February 1, 1973.

d. Every modular factory-built structure, building, building system, component, assembly or system manufactured for installation in Iowa on or after February 1, 1973, shall bear a seal issued by the commissioner which certifies that the unit complies with the code and that the certificates and approvals required by these rules have been submitted or obtained.

e. Every modular factory-built structure, building, building system, component, assembly, or system which was manufactured before February 1, 1973, and which is being installed in Iowa for the first time shall have a seal attached attesting that it complies with the code and that the certificates and approvals have been submitted to the commissioner.

f. Modular factory-built structures moved or relocated after the first installation in Iowa shall comply with the applicable codes and zoning restrictions of the jurisdiction into which it is being moved or relocated.

16.610(3) *Definitions.* Definitions in Division I of this code also apply to Division VI. These definitions also apply to all parts of Division 6. This subrule covers terms and definitions that are defined for purposes of clarification when used in Division VI.

"Building." A combination of materials, whether portable or fixed, to form a structure affording facilities or shelter for persons, animals or property. The word "building" includes any part of a building unless the context clearly requires a different meaning.

"Building component." Any part, subsystem, subassembly, or other system designed for use in, or as part of, a structure, including but not limited to: structural, electrical, mechanical, fire protection, or plumbing systems, and including such variations thereof as are specifically permitted by regulation, and which variations are submitted as part of the building system or amendment thereof.

"Certificate of compliance." A certification which is filed with the commissioner which indicates that the third-party agency has approved specific models or model groups of factory-built structures as meeting the state building code. (See 16.610(14)*"d"* and 16.610(17).)

"Closed construction." Is any structure, building, component, assembly or system manufactured in such a manner that all portions cannot be readily inspected at the installation site without disassembly, damage to, or destruction thereof.

"Code compliance certificate." Is the certificate prepared by an approved manufacturer and submitted by the manufacturer for each unit which is to be installed in Iowa and includes an Installation Certificate. (See subrules 16.610(19) and 16.610(20).)

"Component." Any part, material or appliance which is built in as an integral part of the factory-built structure during the manufacturing process, or any factory-built system, subsystem or assembly not approved as part of a unit, section, or module.

"Evaluation or inspection agency." Is an approved person or organization, private or public, determined by the commissioner to be qualified by reason of facilities, personnel, experience and demonstrated reliability and independence of judgment, to investigate, evaluate and approve factory-built structures or buildings, building components, building systems, and compliance assurance programs.

"Factory-built structure." Is any structure, building, component, assembly or system which is of closed construction and which is made or assembled in manufacturing facilities, on or off the building site, for installation or assembly and installation, on the building site. Factory-built structures may also mean, at the option of the manufacturer, any structure or building of open construction, made or assembled in manufacturing facilities away from the building site, for installation, or assembly and installation, on the building site. Factory-built structure also means "factory-built unit."

"Independence of judgment." Means not being affiliated with or influenced by or controlled by building manufacturers or producers, suppliers, or vendors of products or equipment used in factory-built structures or buildings and building components in any manner which is likely to affect their capacity to tender reports and findings objectively and without bias.

"Manufacturer's bill of sale" means any document, certificate, sales receipt, etc., signed by the manufacturer or importer that the modular factory-built structure described has been transferred to the person or dealer named. The document shall have attached a copy of the 3A section of the Code Compliance Certificate or shall contain at least the make, model year, manufacturer's serial number, Iowa model approval number and the code compliance seal number of the unit.

"Model or model groups." One or more manufacturer-designed modular homes which can constitute one model group.

"Modular." A general term to describe all factory-built structures which are not manufactured homes, manufactured home add-on units, or temporary field construction offices, as defined in Part 2, at 661—16.620(103A). Modular includes, but is not limited to, panelized units, components, sections and modules.

"Module." A unit or a section which is assembled in its final form and transported in such a manner.

"Open construction." Is any structure, building, component, assembly or system manufactured in such a manner that all portions can be readily inspected at the installation site without disassembly, damage to, or destruction thereof.

"Seal" or *"insignia."* A device or insignia issued to the manufacturer by the commissioner for affixing to a factory-built structure or system evidencing compliance with the code.

"Section." A division of a factory-built structure that must be combined with other sections to form a complete structure.

"Structure." That which is built or constructed, an edifice or building of any kind, or any piece of work artificially built up or composed of parts joined together in some definite manner except transmission or distribution equipment of public utilities. The word "structure" includes any part of a structure unless the context clearly requires a different meaning.

"Testing agency." An organization approved by the commissioner which:

1. Is qualified and equipped for the testing, observation, evaluation, or approval of building components, construction, materials, equipment, or systems as regulated by approved standards;
2. Is not under the jurisdiction, affiliation, influence, or control of any manufacturer or supplier of any industry;
3. Makes available a published report in which specific information is included certifying that the equipment and installations listed or labeled have been tested and found acceptable according to approved standards.

"Third-party agency." Is an approved person or organization, private or public, determined by the state building code commissioner to be qualified to act as an evaluation, inspection, testing, or listing agency, as defined in this section.

"Unit." A single factory-built structure approved by the state building code commissioner. Units may be combined to form a larger complex structure or may be a combination of sections.

16.610(4) *Administration.* This section covers the basic requirements for constructing modular structures and all of the administrative procedures under which the modular program functions including methods of certification approval and manufacturing requirements, inspection and installation.

16.610(5) *Modular construction requirements.* All factory-built structures not designated as a manufactured home, manufactured home add-on or a temporary field construction office shall be constructed to the requirements in Division I, Part 4, Division II, Division III, Division IV, or the alternate method of construction as provided for in Division V, Division VII whenever applicable and Division VIII of the state building code.

16.610(6) *Modular installation requirements.* All factory-built structures designated as modular units shall be installed according to the manufacturer's approved installation drawings and any additional state-approved requirements. All approvals shall be part of the third-party certification agency approval for their respective manufacturer. In addition, all installations shall comply with local building codes for items not included as part of the state approval and local zoning requirements whenever applicable.

Modular installers shall obtain approval as required by rule 661—16.622(103A).

Modular installation seals shall be obtained and attached upon completion and the installation certificate shall be completed and filed as per subrule 16.610(20).

16.610(7) *Procedures for approval.* The method of third-party certification and approval shall be used. The manufacturer shall contract with third-party agencies for third-party approvals and notify the building code commissioner of the intent to manufacture units to be installed in Iowa and the name of the third party or parties to be used.

The third-party agency (or agencies) shall also notify the commissioner that they have entered into a contract to perform services with the manufacturer.

Third-party approvals are required for plan and design approval, plant facilities approval and a continuing inspection of units during manufacture.

The manufacturers shall submit plans to the third-party agency or agencies for review and approval. After the plans, the plant facilities, and an inspection procedure have been approved by the third-party agency or agencies the manufacturer shall submit a compliance certificate on the form supplied by the commissioner for each model or model group. The commissioner will assign an Iowa approval number for those models included in the approval.

At the time of production of units for installation in Iowa the manufacturer shall obtain from the commissioner Iowa insignia seals for manufacture and installation, to be attached to the units at the time of manufacture and installation, as well as code compliance and installation certificates.

16.610(8) *Requirements and procedures for obtaining third-party agency approval.*

a. The commissioner or the commissioner's designated representative shall be responsible for approving any person, state or organization who submits an application to the commissioner for approval and whose application is accompanied by written material evidencing that said agency is:

1. Capable of discharging without bias the responsibilities assigned by these regulations.
2. Not under the jurisdiction or control of any manufacturer or supplier of any industry.
3. Professionally competent with independence of judgment to perform the function for which commissioned.
4. Qualified to submit all findings regarding code compliance in a detailed report to the commissioner.
5. Willing to be inspected and reviewed by the commissioner for all phases of work.

b. The commissioner, in considering the information supplied with the application for approval, may limit the agencies' approval to particular types of factory-built structures, buildings, building systems, components, assemblies or systems.

c. Other states wishing to exercise application with this state in order to act in the capacity of an approved third-party agency, may do so provided that:

1. The state laws for issuing seals or insignia for code compliance are equally effective as those specified in this code.
2. The conditions in "1" are enforced in their state.
3. Other states agree to monitoring of this reciprocal agreement by representatives of this state assigned by the commissioner.
4. Violations of any condition as part of the reciprocal agreement may be deemed just cause for revocation or suspension of this agreement by the commissioner.

16.610(9) *Third-party agency responsibilities.*

a. Evidence of approval by the state must be on file at each manufacturing facility.

b. Notify the commissioner when they have contracted with a manufacturer to serve as their third-party agency.

c. Manufacturer plans and specifications must be approved by the third-party agency.

d. File of all plans and documents must be maintained at each manufacturing facility and in the third-party agency office.

e. Send a report to the commissioner stating that the plans and specifications are in compliance with the Iowa state building code.

1. Plans and specifications are not necessary for submittal with this report.
2. A list of approved models for each manufacturing facility.
3. Verify that all engineering documents have been signed by a registered engineer or architect.
4. Update the report as necessary.
5. Indicate approval of installation procedures for all of these structures as well as the personnel who will be doing the installation. However, installation of factory-built structures shall be, in addition to provisions of this code, in accordance with any local ordinances which apply. (That is, those construction processes which are not included as part of the state approval.)

f. Notify the manufacturer of plans and specifications approval including model numbers for use in preparing certificates of compliance.

g. Inspect manufacturing facilities and review or establish a quality control program and test procedure.

h. Notify the manufacturer of facilities approval for use in preparing certificates of compliance.

i. Prepare an inspection manual to be used by the third-party inspectors and the commissioner. This manual shall be on file at each manufacturing facility.

j. Report to the state outlining in-plant procedures and include a typical inspection checkoff sheet.

k. Notify the manufacturer when in-plant inspection program is in force for use in preparing certificates of compliance.

l. Report each quarter to the state for each manufacturer and submit information as follows:

1. Account for all Iowa seals used by each manufacturer during the quarter.
2. Manufacturer's serial number and model number.
3. Third-party seal number.
4. Iowa seal number.
5. The portion of the unit which was actually inspected during an in-plant inspection.

16.610(10) *Third-party agency documentation and plan verification.* The third-party agency will be responsible for the investigation, evaluation, review of test results, of plans and documents, and each revision thereto submitted to the agency by the manufacturer with which it has a contract for compliance with applicable requirements set forth in this code. Such a review shall include but not be limited to:

a. All documentations and plans shall indicate the manufacturer's name, office address, and manufacturing facility address.

b. Manufacturer's plans shall show all elements relating to specific systems on drawings properly identifiable.

c. Each plan which contains material requiring engineering evaluation shall bear the signature and seal of a registered architect or engineer.

d. The plans shall also indicate the method of evaluation and inspection for all required on-site testing of each system.

e. Plans shall designate all work to be performed on site, including all system connections, equipment and appliances and all work performed within the plant.

f. Space shall be provided on all sheets of plans near the title box for the approved stamp.

g. Individual system design or any structural design or method of construction and data shall be in accordance with the Iowa state building code. Plumbing, electrical, heating and mechanical systems constitute individual system designs.

h. Grade, quality, and identification of all materials shall be specified.

i. Design calculations and test reports shall be submitted when specified or required.

j. Plans shall be drawn to scale.

k. Plans shall indicate the location of the approved seal and data plate locations.

l. Copies of approved plans showing third-party agency approval shall be on file at each manufacturing facility or made readily available.

m. Review and approval of all installation procedures must conform to the following:

1. Crews performing installation which are under the jurisdiction of the unit manufacturer or the manufacturer's designee, are approved as competent by the authorized third-party agency.

2. Copies of the installation manual must be available during installation for use by the commissioner or the commissioner's representative or by the local building official.

16.610(11) *Third-party agency plant investigation for quality control.* All manufacturing facilities shall be inspected to the performance objectives as stated in the Iowa state building code. These include as follows:

a. Review of the manufacturer's quality control manuals or establishing a quality control procedure to ensure code compliance.

b. Implementation of inspection and test procedures which will control the quality of fabrication and workmanship.

c. Making a complete report to the commissioner that includes certification of all manufacturing procedures.

16.610(12) *Third-party agency in-plant inspections.* To ensure compliance with the approved specifications and plans and the Iowa state building code and in conjunction with monitoring each manufacturer's quality control program, every approved third-party agency shall:

a. Maintain a record of inspections and such records shall be reported to the commissioner every quarter and include the seal report.

b. Witness and verify all required testing in accordance with the quality control manual.

c. Certify that all seals are being attached as required and only after each unit meets the code requirements.

d. Prepare a detailed inspection manual that specifies the third-party agency procedures in making the required inspections and have this manual available for use by the commissioner or the commissioner's representative when periodic monitoring is performed.

e. One hundred percent inspection is not required, however some part of every unit is required to be inspected. A complete inspection of a typical structural, plumbing, heating and electrical system shall be made each visit to the manufacturing facility.

16.610(13) *Reapproval of third-party agencies.* Any agency approved by the commissioner or the commissioner's designated representative must file for reapproval annually. Such application for reapproval may be filed at any time from the forty-fifth day prior to the scheduled annual expiration date of the current approval. The applying third-party agency seeking reapproval shall completely and accurately furnish all pertinent information as is necessary to make current the information previously submitted to the commissioner or the commissioner's representative as part of its original application for approval and all subsequent applications for reapproval. The application for reapproval shall then become a permanent record of the department administering the provisions of the code. Should there be no change in the status of the applying agency from its original application for approval, an affidavit to that effect shall suffice for consideration of approval.

16.610(14) *Requirements and procedures for modular manufacturers.*

a. Every manufacturer shall be responsible for all corrective actions required and the contractual agreement that each has with the approved third-party agency shall not diminish this responsibility.

b. Every manufacturer shall notify the building code commissioner that the manufacturer's facility desires to construct units which are to be installed in the state of Iowa.

c. Every manufacturer shall contract with an approved third-party agency to perform all duties listed in 5.610(9), 5.610(10), 5.610(11), and 5.610(12). The commissioner will furnish a list of approved third-party agencies upon request.

d. Every manufacturer shall file certificates of compliance with the commissioner for each model or model group, after all third-party reviews are completed. Whenever additional models or changes are proposed, the manufacturer shall file additional certificates of compliance or request that additions be made to existing model lists.

e. Every manufacturer shall notify the commissioner in writing within 60 days after the effective date of this code, the current Iowa approval(s) number that the manufacturer has been assigned and the models which will be manufactured to these standards. Approvals which have not been reaffirmed within this 60-day period shall be considered to be canceled.

f. Every manufacturer shall purchase Iowa seals from the office of the commissioner in accordance with requirements of 5.610(22).

g. All units or sections shall have seals if manufactured after February 1, 1973, and if they are to be installed in Iowa. Regardless of manufactured date, all units being installed in Iowa for the first time shall have a seal attached.

h. Every manufacturer shall complete and furnish compliance certificates and installation certificates in accordance with the requirements of 16.610(19) and 16.610(20).

16.610(15) *Manufacturer's data plate for modular units.* The following information shall be placed directly or by reference on one or more permanent manufacturer's data plates in the vicinity of the electrical distribution panel box or in some other designated location that is readily accessible for inspection.

a. Manufacturer's name and address.

b. Serial number of the structure or unit.

c. Model designation and name of each of the manufacturers of major factory-installed appliances.

d. Wherever applicable, identification of permissible type of gas for appliance and direction for water and drain connections.

e. Name and date of the standards complied with in construction of this structure or unit.

f. The seal serial number.

g. Design loads and special conditions or limitations.

h. Date of manufacture.

i. Electrical ratings. Instructions and warnings on voltage, phase size and connections of units and grounding requirements.

16.610(16) *Changes and alterations to factory-built structures.*

a. Changes to approved plans, drawings or installation instructions proposed by the manufacturer or third-party agency are to be requested in writing and submitted to the building code commissioner. All work being performed in the manufacturing plant that is affected by these changes will not proceed until written approval is received from the commissioner. Where these changes do not affect code compliance, then approval is permitted when changes are authorized through the third-party agency and said changes are then incorporated into the design documents.

b. The commissioner shall notify the manufacturer and the third-party agency of all amendments, deletions or additions to the code provisions and the commissioner shall allow the manufacturer a reasonable time frame in which to submit a request for a change in plan approval, if required, in order to conform to the code change.

c. Basic changes in manufacturing facility locations, company name or address changes, and changes resulting in companies changing ownership or dissolving their business are all to be reported

promptly to the commissioner, in writing, generally within a two-week period after said change was made. The manufacturer shall also notify the third-party agency of said changes.

d. Alterations to factory-built structures pursuant to the construction, plumbing, heat producing, electrical equipment or installation or fire safety in a unit after an Iowa seal has been affixed are all considered to be subject to the same requirements that exist for any structure within the local jurisdiction.

e. The following shall not constitute an alteration to a factory-built structure.

(1) Any repairs to approved component parts.

(2) Conversion of listed fuel-burning appliances in accordance with the terms of their listing.

(3) Adjustment and maintenance of equipment installed in the factory-built structure.

(4) Replacement of equipment in kind.

16.610(17) *Certificate of compliance.* The manufacturer shall provide the building code commissioner with a certificate of compliance for each model or model group of the approved modular design. This certification shall include the following:

a. Model or model group number which will appear on the data plate and compliance certificate.

b. The signature of an authorized representative of the manufacturer.

c. The name of the third-party agency certifying compliance with the code, for each of the three certifications.

d. Evidence of code compliance certified by the third-party agencies, for the specific model or model group being submitted.

16.610(18) *Limitations.* For all types of structures other than one- and two-family dwellings, there shall be, with the certificate of compliance, an attached statement which sets out the limitations of the structure based on site conditions, type of construction, area, and height limitations. A statement to the effect that the structure should not be used except where it meets these conditions will not be acceptable.

16.610(19) *Code compliance and installation certificates.* Code compliance and installation certificates approved for use are available at the Web site of the building code bureau when seals are purchased pursuant to subrule 16.610(22). The manufacturer shall complete the certificate and distribute it as follows:

a. A copy shall be returned to:
State Building Code Bureau
Department of Public Safety
215 East Seventh St.
Des Moines, Iowa 50319

b. A copy shall be retained for plant records and shall be used to make additional copies if necessary. An additional copy shall accompany other shipping documents carried by the transporter and be available for inspection by any authorized official or department.

c. A copy of the compliance certificate shall be forwarded to the dealer, distributor, or any other person who is required to obtain a local building permit or to oversee installation.

16.610(20) *Installation certificates.* The installation certificate portion of the supplied combination certificate (see subrule 16.610(19)) shall be partially completed by the manufacturer at the same time the code compliance certificate is prepared and made part of the documents shipped with the unit and shall be completed by the local building official or the installer.

a. When a building permit is required, a copy of the code compliance certificate shall be presented to the local building official at the time application for a permit is made. The building official shall sign the certificate and send a copy to the commissioner at the address designated in this rule.

b. When a building permit is not required, the code compliance certificate shall be signed by the installer and forwarded to the commissioner at the address designated in this rule.

16.610(21) *Certification seals.* There shall be two seals attached to every factory-built structure which is installed in Iowa.

a. Every module, unit, section, or component shall have a state seal securely affixed at the manufacturing facility to show that the manufactured unit is in compliance with the code. When components and systems are included within a module, section or unit and have been approved by the third-party agency to be part of that module, section or unit, only one seal is required for the module,

section, or unit. A series of panels which make up the final unit when assembled at the site, and where approved in that manner, require only one seal.

b. Every completed unit when installed at the final site shall have an installation seal attached to show that the installation is in compliance with the requirements of this code.

16.610(22) *Seals.*

a. Seal issuance. The state seal shall be issued by the state building code commissioner upon application and after approval of the plans and manufacturing procedures has been certified by the third-party agency evidencing compliance with this code. Applications for seals shall be made to the commissioner on the supplied form and shall include the following:

(1) Number of seals requested.

(2) Iowa model or system approval numbers.

(3) Reference to approval of manufacturing procedures and third-party agency or agencies involved.

(4) A statement by the applicant that consent is given for inspection and investigation at all reasonable hours.

(5) Appicable seal fees.

b. Seal reporting. Manufacturers shall notify the commissioner monthly of the use of seals by the manufacturers' facilities. This information shall be on a form approved by the commissioner and shall contain adequate information to determine the following:

(1) Seal number.

(2) Serial number of the unit on which the seal was placed.

(3) Make and model of the unit on which the seal was placed.

(4) Number of sections that comprise the finished unit.

(5) Location to which the unit was shipped.

16.610(23) *Number of seals required.* Each modular building shall have a seal attached to every section or unit of the building.

16.610(24) *Seal placement on modular units.* Every seal shall be assigned and securely affixed to a specific section or unit. Assigned seals are not transferable and are void when not affixed as assigned. All seals not properly affixed shall be returned to or may be confiscated by the commissioner. The seal shall remain the property of the commissioner in the event of violation of the conditions of approval. Every seal shall be placed on and affixed to each section or unit in a readily visible location within the unit.

16.610(25) *Denial and repossession of seals.* Should investigation or inspection reveal that a manufacturer is not constructing modular units in accordance with the plans approved by the third-party agency, and such manufacturer, after having been served with a notice setting forth in what respect the provisions of these rules and the code have been violated, continues to manufacture units in violation of these rules and the code, applications for new seals shall be denied and the seals previously issued shall be confiscated. Upon satisfactory proof of compliance such manufacturer may resubmit an application for seals.

16.610(26) *Seal removal.* In the event that any unit bearing the seal is found to be in violation of the code, the commissioner may remove the seal (after furnishing the owner or the owner's agent with a written statement of such violations). No new seals shall be issued until proof of corrections has been submitted to the commissioner.

16.610(27) *Lost or damaged seals.* When or if a seal has been lost or damaged, the commissioner shall be notified immediately in writing by the manufacturer. The manufacturer shall identify the unit serial number, and when possible, the seal number.

a. All seals that are damaged shall be promptly returned to the commissioner.

b. Lost and damaged seals shall be replaced by the commissioner with a new seal upon payment of the seal fee as provided in this section.

16.610(28) *Return of seals.* When a manufacturer discontinues production of a unit carrying plan approval, the manufacturer shall within ten days advise the commissioner of the date of such

discontinuance and either return all seals allocated for such discontinued unit or assign said seals to other approved units.

16.610(29) *Fees.*

a. Form of remittance. All remittances shall be:

(1) In the form of checks or money orders;

(2) Made payable to Iowa Department of Public Safety; and

(3) Addressed to:

State Building Code Bureau
Department of Public Safety
215 East Seventh St.
Des Moines, Iowa 50319

b. Seal fees.

Modular code compliance seals	$30 per seal
Modular installation seals	$15 per seal

c. Other fees. A fee equal to the direct expense shall be charged for all other services furnished by the commissioner which are not direct administrative duties of the commissioner's office, including but not limited to obtaining consultants for review and evaluation of applications or obtaining reviews from the national code writing organizations.

16.610(30) *Local issuance of building permits.*

a. The issuance of building permits and occupancy permits shall be in accordance with local ordinances and Iowa Code sections 103A.19 and 103A.20.

b. Local building codes and regulations shall apply to all parts of any project which are not included in the state approval of either the manufactured structure or the installation procedure.

c. Nothing in these rules or the state building code exempts any factory-built structure from the requirements of local zoning or site condition requirements.

16.610(31) *Noncompliance to code provisions.* Any noncompliance or unauthorized deviation with the provisions of this code from the approved plans or production procedures shall be just cause for the revocation of the plan approval and the return of the seals.

[**ARC 8937B**, IAB 7/14/10, effective 7/1/10]

661—16.611 to **16.619** Reserved.

PART 2—MANUFACTURED HOUSING

661—16.620(103A) Manufactured home construction. (Previously called mobile home.)

16.620(1) *Authority to promulgate rules.* Pursuant to Public Law 93-383, Section 604, of the National Manufactured Home Construction and Safety Act of 1974, specified in 42 U.S.C. 5403 and signed into law on August 22, 1974, the authority to promulgate rules and regulations in order to establish federal manufactured home construction standards and procedures of enforcement were established by Congress and subsequent provisions for their implementation were so granted to the United States Department of Housing and Urban Development (HUD). Title VI of this Act authorizes the secretary of HUD to promulgate the federal standards and to issue the rules and regulations to ensure adequate administration and enforcement of such standards.

16.620(2) *Scope and applicability.*

a. Provisions contained within Part 2 shall apply to all factory-built structures defined as a "manufactured home" in subrule 16.620(4) of Part 2. These regulations shall govern manufactured homes that enter the first stage of production on or after June 15, 1976, and manufactured homes that entered the first stage of production prior to June 15, 1976, to which HUD (Department of Housing and Urban Development) labels were affixed. These provisions supersede all local, state, or other governmental regulations for manufactured home standards and are applicable for every manufactured

home unit newly manufactured and offered for sale in the United States and its governing territories. These provisions do not apply to the following:

(1) Factory-built structures which comply with the requirements of Division VI, Part 1 of the state building code.

(2) Manufactured homes manufactured for installation in the state of Iowa on or after February 1, 1973, and prior to June 15, 1976.

b. Construction of multifamily manufactured homes, manufactured home add-on units, and temporary field construction offices will be covered by the provisions of Division VI, Part 2, however, the administration and the enforcement of the rules and regulations will apply as specified in Division VI, Part 1 for modular structures. These units will not bear a seal issued by the Department of Housing and Urban Development, but will bear an Iowa seal and be governed by all seal provisions outlined accordingly in Division VI, Part 1.

16.620(3) *Manufacture of units prior to June 15, 1976.* Manufactured home units, add-on units, multifamily manufactured homes and temporary field construction offices that were manufactured for installation in Iowa prior to June 15, 1976, which established the effective date of the HUD standard, shall have been constructed to the standards of manufactured homes of the Iowa state building code which was in effect at the time of manufacture.

16.620(4) *Definitions and terms.* Terms and definitions for purposes of clarification when used in Part 2. (See also subrule 16.610(3).)

"Anchoring equipment." Straps, cables, turnbuckles, clamps, clips, and other fasteners including tensioning devices, which are used with ties to secure a manufactured home to ground anchors.

"Anchoring system." A combination of ties, anchoring equipment, and ground anchors that will, when properly designed and installed, resist overturning and lateral movement of the manufactured home from wind forces.

"Approved installer." Approval by the commissioner or the commissioner's designated representative of a person, dealer, agency or organization, qualified to inspect, or install ground anchoring and support systems for manufactured homes or other manufactured structures, who installs units, for others, at a site of occupancy by attaching support and anchoring systems, and is familiar with and has agreed to comply with these installation procedures.

"Certificate, installation." The certificate provided by the installer to both the commissioner and the owner which warrants that the installation system complies with these rules. When an installer installs only the support system or anchorage system, an installation certificate shall also be completed and copies distributed accordingly for each installation and with the applicable information completed on the certificate pertinent to that type of installation (see subrule 16.623(5)).

"DAPIA." A design inspection agency approved by HUD to perform in-plant design reviews on all drawings and specifications in order to provide compliance to the HUD standard for manufactured home construction.

"Diagonal tie (frame tie)." A tie intended primarily to resist horizontal or shear forces and which may secondarily resist vertical, uplift, and overturning forces.

"Ground anchor." Any device at the manufactured home site designed to transfer manufactured home anchoring loads to the ground.

"IPIA." A production inspection agency approved by HUD to perform the in-plant quality assurance inspection programs within manufactured home manufacturing facilities.

"Label or certification label." The approved form of certification by the manufacturer that is affixed to each transportable section of each manufactured home manufactured for sale to a purchaser in the United States or its governing territories.

"Main frame" (Chassis). The structural component on which is mounted the body of the manufactured home.

"Manufactured home." (Previously called mobile home.) A structure transportable in one or more sections which when erected on site measures 8 body feet or more in width and 40 body feet or more in length or when erected on site is 320 or more square feet in area, and which is built on a permanent chassis and designed to be used as a dwelling unit with or without a permanent foundation when connected to the

required utilities and includes the plumbing, heating, air conditioning and electrical systems contained therein.

"Manufactured home add-on." A structure which is designed and produced and to be made an integral part of a manufactured home and will be considered part of the manufactured home, when attached thereto.

"Manufacturer's statement of origin" means a certification signed by the manufacturer or importer that the manufactured home described has been transferred to the person or dealer named and that the transfer is the first transfer of the manufactured home in ordinary trade and commerce. In addition to the information required by the Iowa Department of Transportation definition 761—subrule 421.1(2), the label number required by the federal regulations Section 3282.362(c)(2) 24 CFR Chapter XX shall be included. (This number is commonly known as the HUD number.) The terms "manufacturer's certificate," "importer's certificate," "MSO" and "MCO" shall be synonymous with the term "manufacturer's statement of origin."

"Multifamily manufactured home." Manufactured homes designed and manufactured with more than one living unit.

"Pier." That portion of the support system between the pier foundation and the manufactured home exclusive of caps and shims.

"Pier foundation (footing)." That portion of the support system that transmits loads directly to the soil, and shall be sized to support the loads shown herein.

"SAA." A state administrative agency approved by the Department of Housing and Urban Development to participate in the enforcement of all provisions to which a manufactured home is regulated under the HUD standard.

"Seal, installation." Is an insignia issued by the commissioner which is attached to a manufactured home by the installer to certify that the installation is in compliance with the requirements of the state building code.

"Stabilizing system (tie-down system)." A combination of the anchoring system and the support system when properly installed. Therefore, components of the anchoring and support systems such as piers, pier foundations, ties, anchoring equipment, anchors, or any other equipment which supports or secures the manufactured home to the ground, shall be defined as stabilizing devices. For the purposes of this code the definition of a stabilizing system and the definition of a tie-down system shall be one and the same.

"Support system." A combination of pier foundations, piers, caps, and shims that will, when properly installed, support the manufactured home.

"Temporary field construction office." A factory-built structure used at a construction site as an office facility by the personnel engaged in the construction of another structure or project. The intent of this structure is to remain on the job site only as long as necessary during the construction and then be removed before construction is completed.

"Tie." Strap, cable or securing device used to connect the manufactured home to ground anchors.

"Tie-down system (stabilizing system)." Means a ground support system and a ground anchoring system used in concert to provide anchoring and support for a manufactured home.

"Vertical tie (over-the-top)." A tie intended to resist the uplifting and overturning forces. This tie may continue over-the-top but if properly attached may only extend partway up each side.

16.620(5) *Administration.* This section covers the basic requirements for constructing manufactured homes and all of the administrative procedures under which the manufactured home program functions including information pursuant to certification, approval and manufacturing requirements. This section also applies to those structures defined in subrule 16.620(4) of Part 2 as manufactured home add-on units, temporary field construction offices and multifamily homes. There are also included within Part 2, (661—16.621(103A)) sections dealing with installation procedures and information pursuant to the handling of consumer complaints (16.620(15)) consistent with the duties of the state of Iowa to be performed as a State Administrative Agency (SAA) in conjunction with the manufactured home program.

16.620(6) *Manufactured home construction requirements.* All factory-built structures that are defined as a manufactured home under subrule 16.620(4) of Part 2, shall be constructed to the standards

as promulgated by the United States Department of Housing and Urban Development hereafter referred to as HUD. These standards were published as final rules in the December 18, 1975, issue of the Federal Register, Volume 40, No. 244, and will be amended from time to time. These standards are herein adopted and apply to all manufactured homes manufactured after June 15, 1976. All provisions for manufactured home procedural and enforcement regulations are covered within the May 13, 1976, Federal Register, Volume 41, No. 94. All factory-built structures defined as a manufactured home by the federal standard shall be manufactured and so regulated by these documents.

16.620(7) *Procedures of approval for manufactured homes.* Every manufactured home unit or structure approval will follow the method of third-party certification approval with all approvals obtained through the HUD secretary. All manufactured home plans, specifications, documentation, plant facilities and in-plant inspections must be submitted to and approved by a third-party certification agency so designated by the HUD secretary. Rules and regulations pursuant to these procedures are outlined in the manufactured home procedural and enforcement regulations, Parts 3282.201 through 3282.204 which set out requirements to be met by states or private organizations which wish to qualify as primary inspection agencies (see subrule 16.620(4) of Part 2 definitions for IPIA and DAPIA).

16.620(8) *Compliance certification.* Every manufactured home unit or structure must conform to the certification requirements within section 3282.205 of the manufactured home procedural enforcement regulatory document.

16.620(9) *Certification seals (labels) and other seal requirements.* Every manufactured home unit or structure must conform to the requirements within the manufactured home procedural and enforcement regulatory document section 3282.362(c)(2) in lieu of Iowa insignias. Other types of units manufactured under the requirements of Division VI, Part 2, will be labeled as prescribed in subrules 16.620(10), 16.620(11) and 16.620(12).

16.620(10) *Manufactured home add-on units.* Every factory-built structure manufactured as a manufactured home add-on unit as defined in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of manufactured home add-on units with the exception of constructing to the HUD standard, which has been herein adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, for the factory-built structures.

16.620(11) *Multifamily homes.* Every factory-built structure manufactured as a multifamily home within the definition contained in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of multifamily homes, with the exception of constructing units to the HUD standard which has herein been adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, factory-built structures.

16.620(12) *Temporary field construction offices.* Every factory-built structure manufactured as a temporary field construction office within the definition as contained in subrule 16.620(4) of Part 2 shall be constructed to the standards set forth in subrule 16.620(6) of Part 2 except that these units will bear an Iowa seal in accordance with the provisions of the Iowa state building code, Division VI, Part 1. Manufacturers of temporary field construction offices, with the exception of constructing units to the HUD standard which has herein been adopted for these units, must comply with all other provisions of the Iowa state building code as described within Division VI, Part 1, factory-built structures.

16.620(13) *Seal types for manufactured home add-on units, temporary field construction offices and multifamily homes.* When ordering seals for manufactured home add-on units, temporary field construction offices or multifamily manufactured homes, each manufacturer will indicate the number of each type of seal requested and the letter prefix required. Examples of seals issued are as follows: (A00-0000MH), (B00-0000MH), C, D, and E, etc. Single units are without prefix letters (00-0000MH). For more details, see Division VI, Part 1, subrule 16.610(21).

It is noted that manufactured home type seals shall be attached to all of these type units. All other procedures for seal issuance, removal, damage, repossession and return are to conform with provisions of this code as outlined in Division VI, Part 1.

16.620(14) *Noncompliance.* Failure to conform to the provisions of Part 2 as they apply to the federal standard for the construction of manufactured homes is subject to the penalties where applicable as set forth within Division VI, Part 1. The state of Iowa having adopted the federal standard and the enforcement regulations shall participate in the federal program as an agent of HUD thereby providing assurances to ensure code compliance when these units are offered for sale for subsequent installation within the state of Iowa.

16.620(15) *Consumer complaints.* The state building code bureau serving as an approved State Administrative Agency (SAA) for the Federal Department of Housing and Urban Development shall receive complaints and process them in accordance with the requirements of the federal regulations as outlined in subpart I, paragraph 3282.401, entitled, "Consumer Complaint Handling and Remedial Actions of the Manufactured Home Procedural and Enforcement Document." These specific complaints are categorized as possible imminent safety hazards or possible failures to conform to the federal standard. Imminent safety hazards shall be those items that could result in an unreasonable risk of injury or death to the occupants of the manufactured homes. Failures to conform to the federal standard are those items that do not result in an unreasonable risk of injury or death to the occupants of manufactured homes, but nevertheless do not meet the provisions of the federal standard in some specific manner.

661—16.621(103A) Installation of manufactured homes.

16.621(1) *Authority.* These rules and regulations are to establish minimum requirements for the installation of manufactured homes as authorized by Iowa Code section 103A.7, subsection 3, section 103A.9, and sections 103A.30 to 103A.33.

16.621(2) *Application.*

a. These rules apply to the initial installation of manufactured homes manufactured on or after February 1, 1973, and to factory-built structures manufactured homes before February 1, 1973, which have never been installed in Iowa, and are approved by the commissioner.

b. These rules apply to all manufactured homes, new or used, which are sold in Iowa or sold to be installed in Iowa after September 1, 1977, for new manufactured homes and January 1, 1978, for used manufactured homes. The seller shall provide an approved tie-down system and the purchaser shall install or have the system installed within 150 days (see subrule 16.620(4) for the definition of a tie-down system). The 150-day period is designated for time to complete the installation when climatic conditions may restrict the completion of the tie-down system.

c. These rules apply to the installation of manufactured home add-on units, temporary field construction offices and manufactured multifamily homes.

d. These rules shall apply to any person doing any work on any part of the tie-down system (both support or anchorage systems) whether the unit is being sold or not.

16.621(3) *Enforcement.* The commissioner shall administer and enforce these provisions. Any person, agent, or organization approved and authorized by the commissioner may inspect any installation system and equipment to ensure compliance with these regulations. Evidence of compliance shall be supported by the submission to the commissioner of a certificate of installation. One copy of such certificate will remain in possession of the owner of the installed structure.

16.621(4) *Manufactured home installation instructions.* Every manufactured home manufacturer which manufactures manufactured homes for installation in Iowa shall provide the commissioner with a reproducible copy of printed instructions of installation for each specific make and model of manufactured home which is to be installed in Iowa. These instructions shall include copies of the materials which have been certified by a registered professional engineer for compliance with the federal manufactured home construction standards and 3280.306(a)(2), 3280.306(b), and 3280.303(c) of the regulatory standards. The manufacturer's installation instructions shall also be available at the installation site.

16.621(5) *Approvals and procedures.* Requirements for approval of installers, support and anchorage systems, seals and certificates are described in the remaining sections of this part.

661—16.622(103A) Certification of manufactured home installers. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.623(103A) Installation seal and certificate procedures for manufactured homes.

16.623(1) *Application for seals.* Any installer who has met the applicable requirements of 661—Chapter 374 may apply for installation seals as needed. Such seals may be obtained from the commissioner or local building officials or building department who is a participant in the state's installation program.

16.623(2) *Manufactured home installation certificates.* The installer of manufactured homes shall supply the building code commissioner and the owner of the unit with the signed and completed installation certificate which has been issued by the Iowa building code commissioner, within 30 days of affixing the Iowa installation seal.

16.623(3) *Obtaining installation certificates.* Any person who installs a tie-down system or any portion thereof shall be supplied with the installation certificate forms when ordering installation seals and the payment of the appropriate fee.

a. Installers who are not listed as an installer shall be supplied the proper form to be attached to the copy of the installation certificate to be filed with the commissioner, which will record compliance with the approved system.

b. Reserved.

16.623(4) *Placement of installation seal.* The installation seal shall be placed in a readily visible location on the rear of the unit. Those units manufactured after June 15, 1976, shall have the installation seal placed adjacent to the federal (HUD) label. Those units manufactured before June 15, 1976, shall have the installation seal placed at the left rear corner above any skirting.

Multiple width units require only one seal for the completed installation. Additions which are added after the initial installation shall have an installation seal on that portion.

16.623(5) *Denial and repossession of installation seals.* Should investigation or inspection reveal that an approved installer has not installed an anchoring system, support system, or the complete tie-down system according to these rules and the code, the commissioner may deny such installer's application for new installation seals and any installation seals previously issued shall be confiscated. Upon satisfactory proof of modification of such installation bringing them into compliance, such dealer or installer may resubmit an application for installation seals.

16.623(6) *Seal removal, installation.* Should a violation of the rules regarding installation be found, the commissioner may remove the installation seal after furnishing the owner or a designated agent with a written statement of such violation. The commissioner shall not issue a new installation seal until corrections have been made and the owner or a designated agent has requested an inspection pursuant to 16.625(1).

16.623(7) *Lost or damaged seals, installation.* When an installation seal is lost or damaged, the commissioner shall be notified in writing. Damaged or lost installation seals shall be replaced by the commissioner upon payment of the replacement installation seal fee as provided in rule 661—322.20(103A).

16.623(8) *Return of seals, installation.* When a dealer or installer discontinues the installation of manufactured homes, the dealer or installer shall notify the commissioner within ten days of the date of such discontinuance and return all unused installation seals which have been issued to the dealer or installer. Installation seals may not be transferred by any dealer or installer after being issued to that dealer or installer.

16.623(9) *Seals for existing manufactured homes.* Seals may be obtained for existing manufactured homes that are tied down in accordance with the requirements of rule 661—16.627(103A).

661—16.624 Reserved.

661—16.625(103A) Inspections and fee structure. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.626(103A) Support and anchorage of manufactured homes. Rescinded IAB 7/2/08, effective 7/1/08.

661—16.627(103A) Approval of existing manufactured home tie-down systems. This rule is to provide a method by which manufactured homes which have been installed prior to August 12, 1983, can be sold without requiring a new tie-down system to be installed and to allow existing manufactured homes which are properly supported and anchored to be sold without installing new support and anchorage systems.

16.627(1) *Sale of a certified unit.*

a. The commissioner shall be notified in writing by the seller of the change of ownership when any manufactured home sold after August 12, 1983, remains in the same location. The installation seal shall remain in place and a copy of the installation certificate shall be supplied to the new owner. Replacement seals and certificates may be obtained if necessary (see subrule 16.623(9)).

b. A certified manufactured home sold after August 12, 1983, which is moved to a new location must obtain a new certificate and seal. However, the existing support and anchorage system may be used if the installer verifies the conditions of use and the installation procedures of the existing systems are met at the new location.

16.627(2) *Sale or acceptance of installed existing units as an owner's option.* Application may be made to the commissioner for approval of an existing manufactured home support and anchor system on one of the following conditions:

a. If the support and anchorage systems were installed by an approved installer and are approved systems.

b. If the existing support and anchorage system has been inspected by an approved installer and the installer attests by signing the installation certificate that to the best of the installer's knowledge, the existing systems are equal to or better than the minimum requirements of this code.

c. If the existing support and anchorage systems are inspected and approved by a registered engineer or architect, and attested to in writing.

d. If the existing support and anchorage systems are inspected by a field inspector with the Iowa state building code and the existing systems are found to be equal to or better than the minimum requirements of this code.

If compliance is met by one of the above procedures and payment of the required fee has been paid, an Iowa installation seal and certificate may then be issued.

661—16.628(103A) Procedure for governmental subdivisions for installation of factory-built structures. Any governmental subdivision which has adopted the state building code or any other building code is required to enforce the state building code requirements for the installation of factory-built structures (see Iowa Code section 103A.9(7)).

Governmental subdivisions who are issuing building permits and are inspecting construction for compliance with the local building regulations shall verify the installation of factory-built structures within their jurisdiction and shall sign the installation certificate and forward the appropriate copy to the commissioner.

1. The local official shall obtain the installation certificate and the installation seal from the person making application for a building permit which includes a factory-built structure.
2. Upon completion and review of the installation the local official shall attach the installation seal to the unit.
3. Governmental subdivisions are permitted to assess fees as may be required by local ordinances.
4. Nothing in this rule is intended to reduce the authority of the governmental subdivision from establishing zoning regulations as outlined in Iowa Code sections 414.28 and 335.30.

661—16.629(103A) Support and anchoring systems submission.

16.629(1) *Submission by manufacturer.* The manufacturer of each manufactured home installed in Iowa shall submit to the building code commissioner a copy of the installation instructions by mail in printed form and in an electronic form acceptable to the commissioner.

16.629(2) *Submission by licensed professional engineer.* A licensed professional engineer who designs a support and anchoring system for use in the installation of a manufactured home in Iowa shall submit to the building code commissioner a copy of the specifications and instructions for the system by mail in printed form and in an electronic form acceptable to the building code commissioner. A support and anchoring system designed by a licensed professional engineer shall not be utilized unless it has been submitted to the building code commissioner in compliance with this subrule.

TABLE 6A

MINIMUM NUMBER OF TIEDOWNS

REQUIRED FOR SINGLEWIDE MOBILE HOMES

MOBILE HOME BOX LENGTH NOT EXCEEDING	MINIMUM NUMBER OF TIEDOWNS PER SIDE	
	DIAGONAL TIES	VERTICAL TIES*
40′-0″	3	2
54′-0″	3	2
73′-0″	4	2
84′-0″	5	2

*If more than minimum number of vertical or diagonal ties have been supplied, they shall all be used.

NOTES:

1. Doublewide mobile homes shall comply with Table 6A except that no vertical ties are required.
2. Wherever a vertical tie and a diagonal tie lie in a plane which is vertical and transverse to the main longitudinal beam, both ties may be connected to the same ground anchor, providing that particular anchor withstands both loadings.
3. This table shall be used only if there are no manufacturers approved installation requirements.

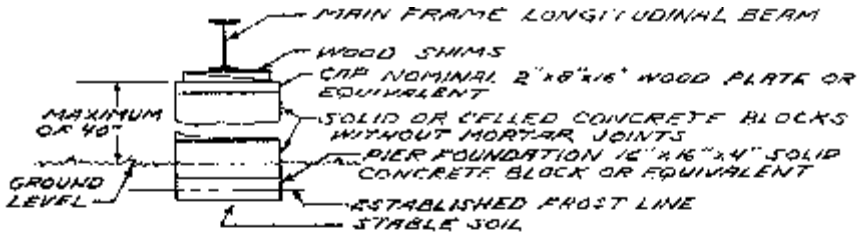


FIGURE 1. PIERS UP TO 40" IN HEIGHT (SINGLE BLOCK CONSTRUCTION)

NOTE: CORNER PIERS MORE THAN THREE (3) BLOCKS HIGH SHALL BE DOUBLE BLOCK CONSTRUCTION AS SHOWN IN FIGURES 2 & 3

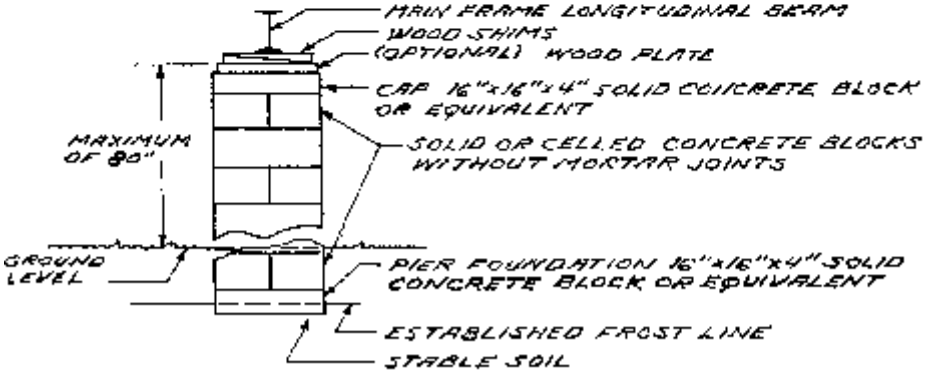


FIGURE 2 - PIERS OVER 40" IN HEIGHT AND NOT EXCEEDING 80" IN HEIGHT (DOUBLE BLOCK CONSTRUCTION)

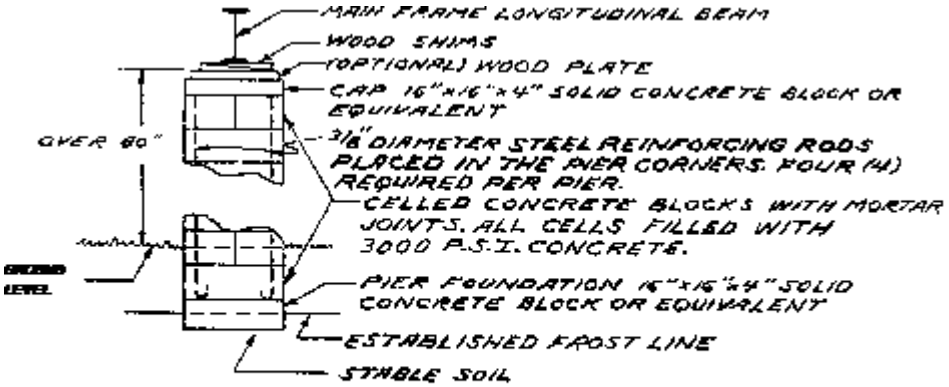
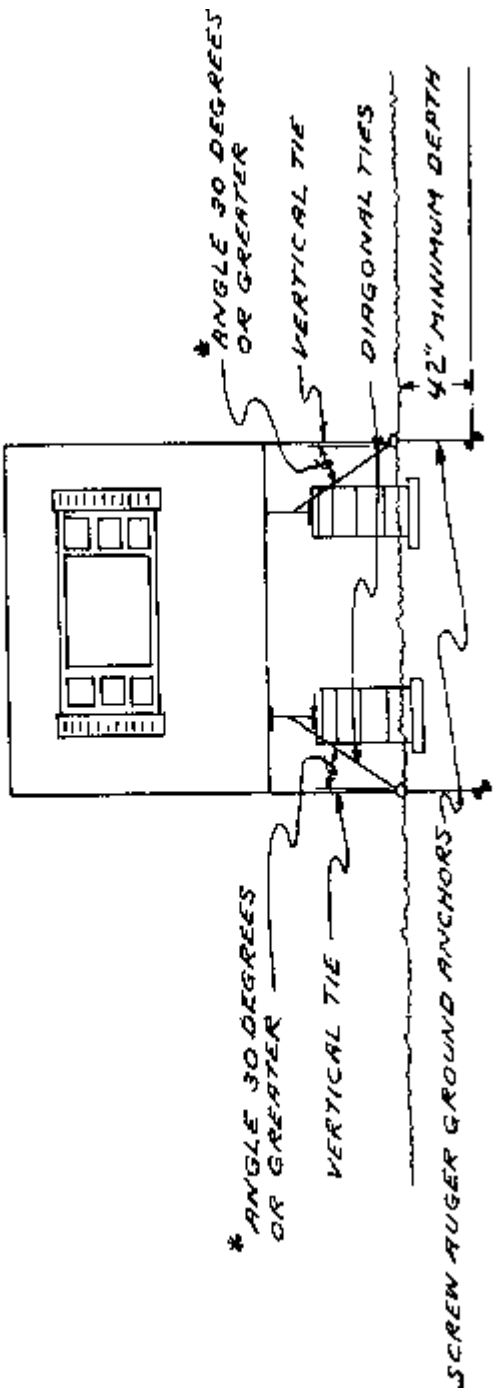


FIGURE 3 - PIERS OVER 80" IN HEIGHT (DOUBLE BLOCK CONSTRUCTION, STEEL REINFORCED)

FIGURE 4

MOBILE HOME TIEDOWN

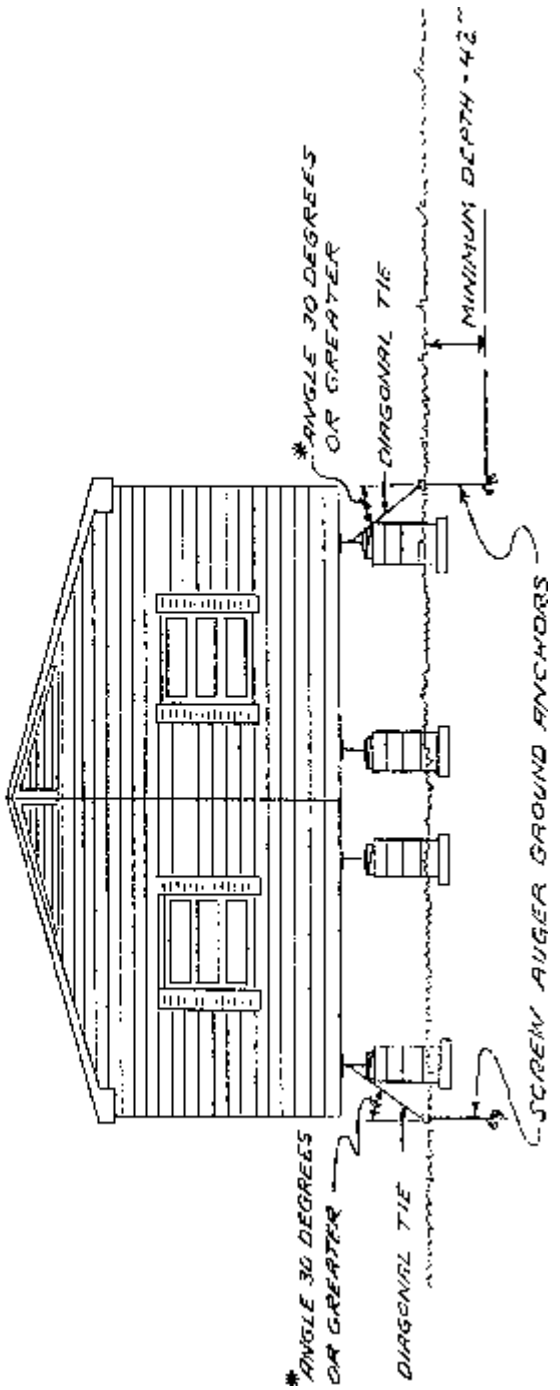


* DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.

FIGURE 5

DOUBLE WIDE MOBILE HOME TIEDOWN

*DIAGONAL TIE SHALL DEVIATE FROM A VERTICAL DIRECTION 30 DEGREES OR MORE.



661—16.630 to **16.699** Reserved.

661—16.700 to **16.720** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapter 302.

661—16.721 to **16.799** Reserved.

661—16.800 to **16.802** Rescinded IAB 12/21/05, effective 4/1/06. See 661—Chapter 303.

These rules are intended to implement Iowa Code section 103A.7 and Public Law 102-486.

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[Filed Emergency ARC 8937B, IAB 7/14/10, effective 7/1/10]

1 Inadvertently dropped out from 1/7/81 IAC Supplement replacement pages.

2 Effective date of IAB amendments to [O.P.P. 5.600 to 5.629] Division VI (16.600 to 16.629) delayed 70 days by the Administrative Rules Review Committee.

3 Effective date (1/1/89) of 16.120(2)[3802 “h” only] delayed until adjournment of the 1988 Session of the General Assembly by the Administrative Rules Review Committee at its December 13, 1988, meeting.

CHAPTER 82
CRIMINAL HISTORY AND FINGERPRINT RECORDS

661—82.1(690,692) Records and identification section. The records and identification section of the division of criminal investigation of the department of public safety maintains information necessary to identify persons with criminal histories. The section collects, files and disseminates criminal history data to authorized criminal justice agencies and to the public upon request and updates criminal history data on a continuing basis.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.2(690,692) Definitions. The following definitions apply to rules 661—82.1(690,692) through 661—82.301(232):

"Authorized agency" means a division or office of the state of Iowa designated to report, receive, or disseminate information under Iowa state law, administrative rule or Public Law 103-209.

"Criminal identification records" means either of the following records, the forms for which are provided by the department to law enforcement agencies:

1. Department of public safety arrest fingerprint cards.
2. State of Iowa final disposition reports.

"Department" means the Iowa department of public safety.

"Division" means the division of criminal investigation of the department of public safety.

"Employee" means a person who provides services and is compensated for those services.

"Fee" means any cost associated with conducting a state or national criminal history record check.

"Felony" and *"misdemeanor"* shall have the same meanings and classifications as described in Iowa Code sections 701.7 and 701.8.

"Fitness determination" means an analysis of criminal history information to determine whether or not the criminal history information disqualifies an individual from holding a particular position or license either as an employee or a volunteer.

"National record check" means a criminal history record check from the FBI that is fingerprint-based and is transmitted through the state central repository.

"Non-criminal justice agency" means an agency that is authorized by law to receive criminal history data from the department; that is not a "criminal or juvenile justice agency" as defined in Iowa Code section 692.1, subsection 7; and that is not an institution which trains law enforcement officers for certification under Iowa Code chapter 80B.

"Qualified entity" means a business or organization, whether public, private, for-profit, not-for-profit or voluntary, that provides care or care placement services, including a business or organization that licenses or certifies persons or entities to provide care or care placement services, treatment, education, training, instruction, supervision or recreation to children, the elderly or individuals with disabilities.

"Taking of fingerprints" means obtaining a fully rolled set of inked fingerprint or electronically scanned fingerprint impressions of suitable quality for fingerprint classification and identification.

"Volunteer" means a person who provides services without compensation.

"Working day" means any day except any of the following:

1. Saturday.
2. Sunday.
3. State holiday.
4. Federal holiday during which the administrative office of the submitting agency is closed.
5. Any day during which the administrative office of the submitting agency is closed or relocated due to weather or road conditions or any condition related to a disaster emergency proclamation issued by the governor pursuant to Iowa Code section 29C.6.

[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.3(690,692) Tracking criminal history data. For audit purposes only, the division of criminal investigation shall establish an internal procedure for tracking criminal history data expunged from the files of the division.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.4 to **82.100** Reserved.

DIVISION I
CRIMINAL HISTORY DATA

661—82.101(690,692) Release of information. Criminal history data maintained by the records and identification section are public records and are released to criminal justice agencies and the public as authorized by statute. Only the department of public safety may release criminal history information maintained by the department to non-criminal justice agencies or persons.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.102(690,692) Right of review. Any person who has a criminal history record on file with the division of criminal investigation has the right to examine and obtain a copy of the record. This right may be exercised by an attorney acting on behalf of a person with a criminal history record only with written authorization and fingerprint identification of the person with the criminal history record. Providing a copy of a criminal history record pursuant to this rule is subject to the fee provided in rule 661—82.109(692).
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.103(690,692) Review of record. An individual or an individual's attorney, acting with written authorization from the individual, may obtain a copy of the individual's criminal history record during normal business hours at the headquarters of the division or by submitting a request on a form provided by the department of public safety. A copy of this request form may be obtained by writing to Division of Criminal Investigation, Iowa Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319; by telephoning the records and identification section at (515)725-6066; or by sending a request by electronic mail to cchinfo@dps.state.ia.us. The request form may also be downloaded from the division's Web site. The completed request form must be notarized, if submitted by mail; be accompanied by a set of the fingerprints of the individual whose criminal history record is being requested; and include submission of the fee established in rule 661—82.109(692). After the record check has been completed, the fingerprints submitted for verification shall be returned, upon request, or destroyed.

NOTE: The Web site of the division of criminal investigation is www.dps.state.ia.us/dci.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.104(17A,690,692) Inaccuracies in criminal history record. If an individual believes inaccuracies exist in the individual's criminal history record, notice may be filed with the division outlining the alleged inaccuracies and should be accompanied by any available supporting data. In all instances where a notice is so filed, the division shall contact the appropriate arresting agencies, courts of record or institutions to verify accuracy of the criminal history record. Any necessary changes shall be made to the individual's criminal history record. Any agency that previously received a copy of the inaccurate record shall be so notified with a corrected copy. A final report shall be made to the individual who filed a notice of correction within 20 days of said filing. If, after notice is filed and the division makes its final report, the individual is still of the opinion that inaccuracies exist within the record, an appeal of the final decision of the division to the Polk County district court may be made.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.105(17A,690,692) Arresting agency portion of final disposition form. The sheriff of each county and the chief of police of each city shall complete the arresting agency portion of the final disposition forms with the arrest information for all persons whose fingerprints are taken in accordance with these rules or Iowa Code section 690.2, and thereafter forward the form to the appropriate county

attorney or, at the discretion of the county attorney, to the clerk of district court, or if the case remains in juvenile court, to the juvenile court officer who received the referral.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.106(690,692) Final disposition form. When a preliminary information or citation is dismissed without new charges being filed or when a case is ignored by a grand jury, the county attorney or juvenile court officer who received the referral shall complete a final disposition form and submit it to the division of criminal investigation within 30 days. When an indictment is returned or a county attorney's information is filed, the final disposition form shall be forwarded by the county attorney to the clerk of the court having jurisdiction. The clerk of court shall forward a copy to the division of criminal investigation within 30 days after judgment. If a juvenile is processed through juvenile court, the juvenile court officer shall forward the disposition form to the division of criminal investigation.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.107(692) Release of information to the public.

82.107(1) The department may release criminal history information to any person or public or private agency upon request by any method approved by the department. Requesters may not receive information regarding arrests older than 18 months that do not have dispositions or deferred judgments when the department has received official notice of successful completion of probation, unless a waiver has been provided to the requester from the person who is the subject of the criminal history information and the waiver is presented to the department at the time the request for the information is made.

82.107(2) Each record released to a non-criminal justice agency shall prominently display the statement: "AN ARREST WITHOUT DISPOSITION IS NOT AN INDICATION OF GUILT."
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.108(692) Scope of record checks for non-criminal justice agencies and individuals. Record checks made for non-criminal justice agencies and individuals pursuant to these rules are based upon name, including maiden name and aliases, if any, and birth date. This information may not be sufficient to effect a precise identification of a subject. A record check based solely upon name and birth date may refer to multiple subjects or may not result in positive identification of the subject of the request. The records of the department are based upon reports from other agencies. The department, therefore, cannot warrant the completeness or accuracy of the information provided. Agencies and individuals that receive criminal history information are therefore advised to verify all information received from the department to the extent possible (e.g., by contacting the reported arresting agency or court).
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.109(692) Fees. All individuals, their attorneys, and other non-criminal justice agencies requesting criminal history information shall be assessed a fee. The department may accept cash, money orders, checks, or credit cards. Other arrangements may be made, such as a prepaid account. The fee for receipt of criminal history information from the department shall be not more than $15 for each name for which information is requested. The fee shall be prominently posted at the headquarters of the division of criminal investigation. Each alias or maiden name submitted shall be considered a separate name for purposes of computing this fee. The employer must pay the cost of the criminal history fee of a potential employee, if the employer requires receipt of criminal history information as a condition of employment.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.110(17A,22,692) Requests for criminal history data.

82.110(1) *Requests for criminal history data.*

a. Persons or agencies requesting criminal history data should direct requests in writing using forms or methods approved by the commissioner of public safety. Forms to use in requesting criminal history information may be requested by mail to the Division of Criminal Investigation, Iowa Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa

50319; by electronic mail to cchinfo@dps.state.ia.us; by telephone at (515)725-6066, or from the Web site of the division.

NOTE: The Web site of the division of criminal investigation is www.dps.state.ia.us/dci.

b. The commissioner may authorize additional methods of requesting criminal history information. These other methods may include fax transmission or computer access. Authorization by the commissioner of public safety shall be based on the ability to securely, efficiently and accurately receive and disseminate criminal history information.

82.110(2) *Public complaints.* Public complaints concerning the operation of criminal history or intelligence data systems should be directed in writing to the commissioner of public safety. Complaints should specify clearly the date, time and place of the alleged violation and any action requested of the commissioner.

82.110(3) *Required approvals.* Any agreement, arrangement or system for the transmission and exchange of criminal history data required to be approved by the commissioner shall be submitted in writing at least 30 days before its proposed effective date.

[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.111(690) Administrative sanctions.

82.111(1) The commissioner of public safety may deny or restrict access to criminal history data maintained by the records and identification section of the division of criminal investigation to any agency that fails to comply with the requirements of Iowa Code chapters 690 and 692 for submission of fingerprints and disposition reports to the department of public safety. The commissioner shall notify the affected agency in writing prior to denying or restricting access and shall provide details of the requirements and the nature of the failure to comply.

82.111(2) Any agency that has received notification from the commissioner that the agency's access to criminal history data is to be denied or restricted may protest this action. Protests must be filed with the administrative services division within 30 days of the date of the notification from the commissioner in accordance with rule 661—10.101(17A).

[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.112(692) Criminal history record checks for qualified entities or authorized agencies.

82.112(1) The department of public safety may process requests for national criminal history record checks for a qualified entity or authorized agency.

82.112(2) All qualified entities or authorized agencies requesting criminal history record checks shall be required to pay any applicable state and federal fees associated with noncriminal justice record checks. The qualified entity or authorized agency is responsible for such fees whether the qualified entity requests or receives the information directly or through an agency authorized to make fitness determinations as provided in subrule 82.112(3).

82.112(3) Any public entity which has been duly authorized by statute or administrative rule to conduct fitness determinations of volunteers or employees of a qualified entity may receive state criminal history record checks in order to do so. Any public entity which has been duly authorized by statute to conduct fitness examinations of volunteers or employees, including national criminal history checks, may receive national criminal history record checks in order to conduct such examinations.

82.112(4) A school district considering an applicant for a teaching position is a qualified entity pursuant to Iowa Code section 279.13. A school district may submit a request for a national criminal history record check of an applicant for employment as a teacher. The request shall be submitted on a form designated by the division of criminal investigation and shall be accompanied by completed fingerprint cards for the applicant and the applicable fee. Prior to submitting the request, the district may contact the division of criminal investigation by telephone at (515)725-6066 or by electronic mail at cchinfo@dps.state.ia.us to obtain instructions on the submission or may consult the Web site of the division for such information.

NOTE: The Web site of the division of criminal investigation is www.dps.state.ia.us/dci.

[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.113 to **82.200** Reserved.

DIVISION II
FINGERPRINT RECORDS

661—82.201(17A,690,692) Fingerprint files and crime reports. The department maintains all fingerprint files.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.202(690) Taking of fingerprints. The taking of fingerprints shall be in compliance with Iowa Code sections 232.148(2), 690.2 and 690.4. Fingerprints taken pursuant to these sections shall be submitted to the records and identification section of the division of criminal investigation within two working days, and the department shall submit the fingerprints to the Federal Bureau of Investigation.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

661—82.203 to **82.300** Reserved.

DIVISION III
JUVENILE RECORDS

661—82.301(232) Juvenile fingerprints and criminal histories.

82.301(1) *Authority to fingerprint.* A law enforcement agency shall fingerprint and photograph any juvenile who has been taken into custody and charged with the commission of an offense which would be a serious misdemeanor, aggravated misdemeanor or felony if committed by an adult. Fingerprints of juveniles taken pursuant to this subrule shall be submitted to the division of criminal investigation.

82.301(2) *Fingerprints of juveniles waived to adult court.* If jurisdiction over a juvenile suspect has been transferred from juvenile court to adult court, then fingerprints of that suspect taken pursuant to Iowa Code section 232.148 and transmitted to the division of criminal investigation shall be handled by the division in the same manner as fingerprints of adult suspects are handled, and the fingerprints are subject to the same provisions of law and these rules which govern fingerprints of adult criminal suspects.

82.301(3) *Fingerprints entered into automated fingerprint identification system (AFIS).* Fingerprints of juveniles shall be entered into the AFIS maintained by the department of public safety.

82.301(4) *Juvenile criminal histories.*

a. A fingerprint card received for a juvenile suspect shall be used to establish a criminal history record for the suspect.

b. Criminal histories of juveniles over whom jurisdiction has been transferred from juvenile court to adult court shall be handled in the same manner as criminal histories of adults.

c. Criminal histories of juveniles who remain under the jurisdiction of the juvenile court shall be maintained only if the juvenile is adjudicated delinquent based upon an offense which would be a serious or aggravated misdemeanor or felony if committed by an adult. The criminal history record established in response to the division's receiving a fingerprint card shall be expunged if the delinquency petition is dismissed. Juvenile court judges shall order that a juvenile be fingerprinted and the prints submitted to the division of criminal investigation if the juvenile has been adjudicated delinquent for an offense which would be a serious or aggravated misdemeanor or felony if committed by an adult.

d. Criminal history data of juveniles over whom jurisdiction has not been transferred from juvenile court to adult court shall be expunged when the subject reaches the age of 21 unless the subject has been convicted of a serious or aggravated misdemeanor or a felony when the subject was between the ages of 18 and 21 or unless the retention of the records is necessary for the purpose of administering Iowa Code chapter 692A. If the subject has been convicted of a serious or aggravated misdemeanor or a felony when the subject was between the ages of 18 and 21, the criminal history record shall be maintained in the same manner as adult criminal history data.
[**ARC 8936B**, IAB 7/14/10, effective 9/1/10]

These rules are intended to implement Iowa Code chapters 690, 692, and 692B.

[Filed ARC 8936B (Notice ARC 8769B, IAB 5/19/10), IAB 7/14/10, effective 9/1/10]

CHAPTER 400
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—GOVERNANCE AND ADMINISTRATION

[Prior to 10/27/04, see 581—Ch 24]

661—400.1(97A) Establishment of system. The Iowa department of public safety peace officers' retirement, accident, and disability system is established by Iowa Code chapter 97A. The administrative rules governing the system are found in this chapter and in 661—Chapters 401, 402, and 403.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—400.2(97A) Definitions. The following definitions apply to 661—Chapters 400 through 403.

"Active member," "actively engaged member" or *"member in service"* means a currently employed peace officer of the Iowa department of public safety who is not reemployed pursuant to Iowa Code section 97A.3, subsection 3.

"Board" means the board of trustees of the system.

"Commissioner" means the commissioner of the Iowa department of public safety who also serves as the chairperson of the board of trustees.

"Department" means the Iowa department of public safety.

"Line-of-duty death" means the death of a member in service which was the direct and proximate result of a traumatic personal injury incurred in the line of duty. Line-of-duty death does not include the death of a member which resulted from stress, strain, occupational illness, or a chronic, progressive, or congenital illness, including, but not limited to, a disease of the heart, lungs, or respiratory system, unless a traumatic personal injury was a substantial contributing factor to the member's death. Line-of-duty death does not include the death of a member if the death results in eligibility for payment of a line-of-duty death benefit pursuant to Iowa Code section 100B.11 and 661—Chapter 291.

"Medical attention" means services provided by licensed medical personnel including, but not limited to, office, hospital, in-home nursing care, nursing home care, long-term care and prescriptions for medicine or equipment.

"Medical board" means a board of three physicians appointed by the board of trustees pursuant to Iowa Code section 97A.5, subsection 8.

"Peace officers' retirement system," also referred to as *"the system,"* means the Iowa department of public safety peace officers' retirement, accident, and disability system.

"Retired member" means a person formerly employed as a peace officer of the Iowa department of public safety who is currently receiving or has received pension benefits from the system.

"Secretary" means an employee of the administrative services division of the Iowa department of public safety designated by the division director to provide staff support to the board.

"System" means the Iowa department of public safety peace officers' retirement, accident, and disability system.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—400.3(97A) Governance. The system is governed by a board of trustees, appointed and elected as provided in Iowa Code section 97A.5, subsection 1. The board of trustees shall have five members, including the commissioner of public safety, who shall serve as chairperson of the board, the treasurer of state, an actively engaged member of the system, a retired member of the system, and a person appointed by the governor.

400.3(1) *Terms of office.* Terms of office of members of the board of trustees are as follows:

a. The commissioner of public safety shall serve a term that is concurrent with appointment as commissioner of public safety.

b. The treasurer of state shall serve a term that is concurrent with the term of treasurer of state.

c. The actively engaged member of the system shall serve a two-year term commencing on July 1 of an odd-numbered year and terminating on June 30 of the next odd-numbered year.

d. The retired member of the system shall serve a two-year term commencing on July 1 of an even-numbered year and terminating on June 30 of the next even-numbered year.

e. The member appointed by the governor shall serve a two-year term commencing on May 1 of the year of appointment and terminating on April 30 in the year of expiration.

400.3(2) *Election of board members.*

a. The actively engaged member shall be elected by secret ballot of the actively engaged members of the system. The retired member shall be elected by secret ballot of the retired members of the system. The actively engaged member shall be elected in odd-numbered years, and the retired member shall be elected in even-numbered years.

b. At least 90 days prior to the start of the term of office for the actively engaged member or the retired member, the secretary shall distribute by regular mail a write-in nomination ballot to each member of the system who is eligible to vote. The deadline for return of the ballots shall be established by the secretary at no less than 30 days nor more than 35 days after the date of distribution of the ballots and shall be printed on each ballot. In order to record a nomination, a member shall return the nomination ballot with a postmark or by personal delivery prior to the deadline specified on the ballot, filled in with the name of the member whom the member casting the ballot wishes to nominate.

c. The secretary shall contact each of the nominees who receive the three highest numbers of nominations to determine if each nominee is willing to serve if elected. For each nominee contacted who is unwilling to serve, the secretary shall contact the next nominee in descending order of nominations until three nominees willing to serve are identified.

d. The names of those three eligible members willing to serve if elected who receive the highest number of write-in nominations shall be placed on an election ballot.

e. The secretary shall distribute by regular mail election ballots to the members of the system who are eligible to vote. The deadline for return of the ballots shall be established by the secretary at no less than 30 days nor more than 35 days after the date of distribution of the ballots and shall be printed on each ballot. Any eligible member who receives a ballot and wishes to vote shall return the ballot to the secretary with a postmark or by personal delivery prior to the deadline printed on the ballot with a choice of one of the three candidates listed indicated. The candidate who receives the highest number of votes shall serve as the actively engaged member or the retired member of the system on the board of trustees.

f. In the event that two of the three candidates tie with the highest number of votes, a new election ballot with the names of the two candidates who tied shall be distributed by regular mail by the secretary to all members who are eligible to vote. The deadline for return of the ballots shall be established by the secretary at no less than 30 days nor more than 35 days after the date of distribution of the ballots and shall be printed on each ballot. Any eligible member who wishes to vote shall return the ballot to the secretary prior to the deadline with the member's preference indicated. The candidate who receives the highest number of votes shall serve as the actively engaged member or the retired member on the board of trustees.

g. In the event that all three candidates receive the same number of votes in the initial election balloting or that the two remaining candidates receive the same number of votes in an election held to break a tie between two candidates, the selection of the board member shall be determined by drawing of lots under the supervision of the commissioner of public safety, acting as chairperson of the board of trustees.

400.3(3) *Vacancies.* A vacancy in a position held by an elected member shall be filled in the same manner as the original election, and the newly elected member shall serve for the balance of the original term for the position filled.

661—400.4(97A) Meetings of board of trustees. The board of trustees shall meet at least quarterly, or upon the call of the chairperson. A quorum of the board shall consist of three members, and three concurring votes shall be necessary for a decision by the board. For purposes of a quorum or for voting, a member may participate in person, by audio conference or by videoconference.

661—400.5(97A) Administrative support. The department provides administrative support to the system, through the administrative services division. The secretary shall be an employee of the department. Employees of the system shall be under the administrative supervision of the director

of the administrative services division. Additional administrative support may be provided by other employees of the department at the direction of the commissioner of public safety.

661—400.6(97A) Forms and information. Persons who wish to obtain forms or information about the peace officers' retirement, accident, and disability system shall address requests to:

Peace Officers' Retirement System
Iowa Department of Public Safety
State Public Safety Headquarters Building
215 East 7th Street
Des Moines, Iowa 50319
(515)725-6248
asdinfo@dps.state.ia.us

[Editorial change: IAC Supplement 6/17/09]

661—400.7(97A) Annual statements.

400.7(1) As soon as practical after the close of each fiscal year, a statement of account shall be furnished to each actively engaged member, which shall include the member's contribution for the year.

400.7(2) As soon as practical after the end of a calendar year, and in any event within any deadlines for this purpose established by the Internal Revenue Service or the Iowa department of revenue, a Form 1099, W2-P or an equivalent shall be prepared for and mailed to each person who received benefits during the year. The form shall detail the total pension paid during the year and shall comply with any applicable requirements established by the Internal Revenue Service and the Iowa department of revenue.

661—400.8(97A) Books of account. The following books of account shall be maintained by the secretary.

400.8(1) Self-balancing combination journal that records all receipts, disbursements and necessary adjustments.

400.8(2) Self-balancing ledger of control accounts.

400.8(3) Schedules at the close of the fiscal year which shall detail all control accounts except:

a. Pension reserve account.

b. Pension accumulation account.

661—400.9(97A) Investments. Investments of assets of the system shall be administered through the office of the treasurer of state. The board of trustees has the authority to direct the investment of funds, including, but not limited to, the execution of contracts with appropriately qualified individuals or firms to provide advice regarding investments.

661—400.10(97A) Medical board.

400.10(1) The medical board shall consist of three physicians, including at least one occupational medicine specialist, with the knowledge and experience to adequately evaluate the fitness for duty of a peace officer.

400.10(2) The board of trustees shall ratify the composition of the medical board and all subsequent changes to the composition of the medical board. The board of trustees may review the composition of the medical board at any time.

These rules are intended to implement Iowa Code chapter 97A.

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CHAPTER 401
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—ADMINISTRATIVE PROCEDURES

[Prior to 10/27/04, see 581—Ch 24]

661—401.1(97A) Applications. Applications for benefits under Iowa Code chapter 97A shall be filed with the secretary on forms provided by the secretary. Applications for service retirement shall be made not more than 90 days nor less than 30 days in advance of the date of retirement. Applications for service retirement, ordinary disability or accidental disability shall be reviewed by the secretary for completeness and then forwarded to the board of trustees.

401.1(1) *Manner of review for ordinary or accidental disability.* The secretary shall compile the following materials, if available and applicable, for the board's review of a claim:

a. The application;

b. Any materials provided by the applicant;

c. Any available medical information in the possession of the board or the state;

d. Any information available through any workers' compensation claims made by the applicant; and

e. Recommendations and reports from the medical board.

NOTE: This subrule does not impose a responsibility on the secretary to discover documents or evidence not in the secretary's possession. It is only intended to outline the types of evidence the secretary should provide to the board if available.

401.1(2) *Commissioner's application.* The commissioner may file an application for ordinary or accidental disability on behalf of a member in service. The secretary shall review such applications in the same manner as those filed by a member. The fact that the commissioner has filed an application on a member's behalf shall not prevent the commissioner or the board from denying the application. All applications for accidental disability benefits shall be deemed cross-filed by the commissioner for the purpose of considering disability benefits. Nothing in this rule prevents the board from denying any application.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—401.2(97A) Determination on initial review.

401.2(1) *Board approval.* The board may approve or deny the application as presented or may direct the applicant to provide further medical information.

401.2(2) *Denial and appeal.* A decision by the board to deny the application may be appealed by the applicant. Written notice of a denial shall be provided to the applicant by certified mail. The written notice shall disclose the applicant's right to appeal, the procedure for filing an appeal, and the deadline for filing an appeal. An appeal must be filed in writing with the secretary within 30 calendar days after the applicant receives written notice of the decision of the board. The board may extend the deadline for filing an appeal. At a minimum, an appeal shall include a short and concise statement of the basis for the appeal.

661—401.3(97A) Applications for reimbursement for medical attention. Member beneficiaries may make application for reimbursement of the costs of medical attention as defined in rule 661—400.2(97A). This rule provides for the requirements of making application for reimbursement, the process for review and disposition of the application, and payment of approved applications.

401.3(1) *Making application.*

a. An application for reimbursement must be filed on a form provided by the secretary within 12 months of the member beneficiary's receiving treatment or incurring a cost for medical attention.

b. In the event there is a dispute with an insurance company regarding covered expenses, to remain eligible for reimbursement, the member beneficiary must file a request for extension, on a form provided by the secretary, if resolution of the dispute is expected to exceed 12 months.

c. Expenses shall only be reimbursed if the member beneficiary is retired as a result of an injury, illness or exposure occurring while in the performance of duty and is receiving a benefit as provided in Iowa Code section 97A.6(6).

d. Expenses shall be reimbursed only if the member beneficiary received medical attention for a condition with direct correlation to the disabling condition, the costs of which were not covered by insurance.

e. The system shall not reimburse for insurance premiums.

401.3(2) *Processing the application.*

a. Upon receipt of the application and supporting documentation, the secretary shall review the application for timeliness, completeness and validity. This subrule does not impose a responsibility on the secretary to discover documents or evidence not included on the application form.

b. The secretary shall refer the written application to the board for review at the next regularly scheduled meeting.

c. The member beneficiary does not need to be in attendance at the board meeting. In order to comply with Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specific information pertaining to an application for reimbursement or the member beneficiary's disabling condition will not be discussed in open forum of the board meeting unless the member beneficiary is present and approves discussion in a public meeting.

d. The board may approve or deny all or part of a reimbursement application. The board may request additional information to support the application for reimbursement or to determine the correlation of the expense to the disabling condition. The member beneficiary shall provide the documents to the secretary within a reasonable time period. In no case shall the application remain valid for a period of more than 12 months.

e. If the board denies any part of a request for reimbursement, the member beneficiary may request judicial review in accordance with Iowa Code section 97A.6(13).

f. The system will make reimbursements only to the member beneficiary or to the surviving spouse in the event the member beneficiary is deceased.

401.3(3) *Other provisions.*

a. Reimbursements for claimed expenses shall be reduced by any amount already received by the member beneficiary from workers' compensation or from a third party as a result of subrogation proceedings entered into as a result of the disabling injury.

b. In the event the member beneficiary is restored to active service pursuant to Iowa Code section 97A.6(7)*"b,"*consideration of reimbursement for expenses pursuant to Iowa Code section 97A.14 shall not extend beyond the date of restoration to active service.

c. If the member beneficiary receiving a disability retirement pursuant to Iowa Code section 97A.6(6) becomes employed in a public safety occupation pursuant to Iowa Code section 97A.6(7)*"d,"* consideration of reimbursement for expenses pursuant to Iowa Code section 97A.14 shall not extend beyond the date of employment with the employing jurisdiction.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—401.4 to **401.100** Reserved.

PROCEDURE FOR RULE MAKING

661—401.101(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules adopted by the board are subject to the provisions of Iowa Code chapter 17A and the provisions of this chapter.

661—401.102(17A) Advice on possible rules before notice of proposed rule adoption. In addition to seeking information by other methods, the board may, before publication of a Notice of Intended Action, solicit comments from the public on a subject or subjects of possible rule making by the board by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment, or by otherwise publicizing the interest of the board in soliciting

comment on a subject or subjects of possible rule making. Any such effort shall include publication of the interest of the board on the department of public safety's Web site and may include publication in any other venue deemed appropriate by the board or officials or staff of the department.

661—401.103(17A) Public rule-making docket. Pursuant to Executive Order 9, the department maintains a current public rule-making docket. All rule-making activity of the board of trustees of the peace officers' retirement, accident, and disability system shall be included in the rule-making docket of the department, including a rule making which has formally commenced with a Notice of Intended Action and an anticipated rule making identified by the board or staff. The rule-making docket is maintained on the Web site of the department.

661—401.104(17A) Notice of proposed rule making.

401.104(1) *Contents.* At least 35 days before the adoption of rules, the agency rules administrator of the department shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

a. A brief explanation of the purpose of the proposed rules;

b. The specific legal authority for the proposed rules;

c. Except to the extent impracticable, the text of the proposed rules;

d. Where, when, and how persons may present their views on the proposed rules; and

e. The date, time and place of an oral proceeding at which any interested party may comment on the proposed rules, or where, when, and how persons may demand an oral proceeding on the proposed rules if the notice does not already provide for one.

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the department shall include in the notice a statement fully describing the specific subject matter of the omitted portion of the text of the proposed rule, the specific issues to be addressed by that omitted text of the proposed rule, and the range of possible choices being considered by the board for the resolution of each of those issues.

401.104(2) *Incorporation by reference.* A proposed rule may incorporate other materials by reference.

661—401.105(17A) Public participation.

401.105(1) *Written comments.* For at least 20 days after publication of the Notice of Intended Action, persons may submit argument, data, and views, in writing, on the proposed rule. Such written submissions should identify the proposed rule to which they relate and should be submitted to the Agency Rules Administrator, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319, or to the person or office designated in the Notice of Intended Action.

401.105(2) *Oral proceedings.* The department may, at any time, schedule an oral proceeding on a proposed rule. If an oral proceeding has not previously been scheduled regarding proposed rules, the department shall schedule an oral proceeding on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the department by the administrative rules review committee, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons.

An oral proceeding may be scheduled or conducted by the board at the discretion of the board or of the chair of the board.

401.105(3) *Conduct of oral proceedings.*

a. Applicability. This subrule applies only to those oral rule-making proceedings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1)*"b"* or this chapter.

b. Scheduling and notice. An oral proceeding on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in

the Iowa Administrative Bulletin. That notice shall also identify the proposed rule by ARC number and citation to the Iowa Administrative Bulletin.

c. Presiding officer. The agency rules administrator of the department of public safety or the administrator's designee shall preside at the oral proceeding on a proposed rule, unless the board conducts the oral proceeding. If the board does not conduct the oral proceeding, the presiding officer may prepare a memorandum for consideration by the board summarizing the contents of the presentations made at the oral proceeding if the administrator determines that such a memorandum would be helpful to the board.

d. Conduct of proceeding. At an oral proceeding on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the department at least one business day prior to the proceeding and indicate the general subject of their presentations. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Oral proceedings shall be open to the public and may be recorded by stenographic or electronic means.

(1) At the beginning of the oral proceeding, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the oral proceeding. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

(2) Persons making oral presentations are encouraged to summarize matters which have already been submitted in writing.

(3) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

(4) Physical and documentary submissions presented by participants in the oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the system.

(5) The oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing. The presiding officer may provide for the record of an oral proceeding to be held open for a specific length of time, announced at the oral proceeding, to allow for the submission of additional information.

(6) Participants in an oral proceeding shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in an oral proceeding may question participants and permit the questioning of participants by other representatives of the board who may be present about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

(7) The presiding officer in an oral proceeding may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.

401.105(4) *Additional information.* In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the board may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

401.105(5) *Accessibility.* The department shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the Agency Rules Administrator, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319, by mail, by telephone at (515)725-6185, or by electronic mail at admrule@dps.state.ia.us, in advance to arrange access or other needed services.
[Editorial change: IAC Supplement 6/17/09]

661—401.106(17A) Regulatory analysis. The agency rules administrator shall prepare a regulatory analysis of proposed rules in compliance with Iowa Code section 17A.4A if requested pursuant to Iowa Code section 17A.4A, subsection 1.

661—401.107(17A,25B) Fiscal impact statement. For each Notice of Intended Action or emergency adoption of rules filed, the staff of the system and the department shall develop a fiscal impact statement in compliance with Iowa Code section 17A.4, subsection 3, and procedures established by the legislative services agency, if the preparation of a fiscal impact statement is required.

661—401.108(17A) Time and manner of rule adoption.

401.108(1) *Time of adoption.* The board shall not adopt a rule until the period for making written submissions and oral presentations has expired. Within 180 days after the later of the publication of the Notice of Intended Action, or the end of oral proceedings thereon, the board shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

EXCEPTION: The board may waive the notice requirements or time periods specified in Iowa Code chapter 17A, in compliance with Iowa Code section 17A.4, subsection 2, or Iowa Code section 17A.5, subsection 2, paragraph *"b,"* or both.

401.108(2) *Consideration of public comment.* Before the adoption of a rule, the board shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

401.108(3) *Reliance on department expertise.* Except as otherwise provided by law, the board may use its own experience, technical competence, specialized knowledge, and judgment, or that of department staff, in the adoption of a rule.

401.108(4) *Adoption by reference.* The board may, by adoption of an administrative rule, adopt by reference another document produced by the board, the department, another agency of Iowa government, a federal agency, or any other organization. If any document or portion of any document is adopted by reference and is not already available in the state law library, the department shall provide a copy of the document for filing in the state law library, in compliance with Iowa Code section 17A.6, subsection 4.

661—401.109(17A) Variance between adopted rule and published notice of proposed rule adoption.

401.109(1) The board shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

a. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and

b. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and

c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

401.109(2) In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the board shall consider the following factors:

a. The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;

b. The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action; and

c. The extent to which the effects of the rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

401.109(3) The board shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of a rule that differs from the proposed rule contained in the Notice of Intended Action upon which the rule is based, unless the board finds that the differences between the adopted rule and the proposed rule are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee, within three days of its issuance.

401.109(4) Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the board to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

661—401.110(17A) Concise statement of reasons. When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the board shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the Agency Rules Administrator, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319. The request should indicate whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received. After a proper request, the board shall issue a concise statement of reasons by the later of the time the rule is adopted or 35 days after receipt of the request. If the board does not meet during the time between the receipt of a request and the deadline for issuance of the concise statement, the staff may issue the concise statement with the approval of the board chair.
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661—401.111(17A,97A) Agency rule-making record. The department shall maintain an official rule-making record for each rule proposed by the board by publication in the Iowa Administrative Bulletin of a Notice of Intended Action, or adopts. The rule-making record and materials incorporated by reference shall be available for public inspection. Requests to view material from the rule-making record may be addressed to the agency rules administrator of the department.

661—401.112(17A,97A) Petitions for rule making. Any person or agency may file a petition for rule making with the secretary at the location specified in rule 661—400.6(97A). A petition is deemed filed when it is received by the secretary. The secretary shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the agency an extra copy for this purpose. The secretary shall transmit a copy of the petition to the agency rules administrator. The petition must be typewritten or legibly handwritten in ink and should substantially conform to the following form:

PUBLIC SAFETY PEACE OFFICERS'
RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM

Petition by (name of petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	PETITION FOR RULE MAKING

The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the board's authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner's arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by or interested in the proposed action which is the subject of the petition.
6. Any request by petitioner for a meeting provided for by subrule 401.112(5).

401.112(1) The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

401.112(2) The board may deny a petition because it does not substantially conform to the required form. However, the board may consider any petition received, regardless of errors or variations in

form, provided that the content of the request for rule making is clear or has been clarified through communication with the petitioner. Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the board's rejection of the petition.

401.112(3) The petitioner may attach a brief to the petition in support of the action urged in the petition. The board may request a brief from the petitioner or from any other person concerning the substance of the petition.

401.112(4) Inquiries concerning the status of a petition for rule making may be made to the Agency Rules Administrator, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319, or via electronic mail at admrule@dps.state.ia.us.

401.112(5) Upon request by petitioner in the petition, the chair of the board may schedule a brief and informal meeting between the petitioner and the board, a member of the board, the secretary, or other staff of the department to discuss the petition. Such meeting shall include the agency rules administrator of the department or another employee of the department knowledgeable about the administrative rule-making process who is jointly designated by the agency rules administrator and the director of the administrative services division of the department. The board may request the petitioner to submit additional information or argument concerning the petition. The board may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the board by any person.

401.112(6) Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the board shall, in writing, deny the petition and notify petitioner of its action and the specific grounds for the denial or grant the petition and notify petitioner that it will institute rule-making proceedings on the subject of the petition. Notice shall be sent by the secretary to the petitioner by regular mail. Petitioner shall be deemed notified of the denial or granting of the petition on the date when the secretary mails the required notification to the petitioner.

401.112(7) Inquiries concerning the status of a petition for rule making may be made to the Agency Rules Administrator, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319, or by electronic mail to admrule@dps.state.ia.us.
[Editorial change: IAC Supplement 6/17/09]

661—401.113(17A,97A) Waivers of rules. This rule outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the board. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede this rule with respect to any waiver from the rule in question.

401.113(1) *Requests for waivers.* Requests for waivers of rules shall be addressed to the secretary. A request shall state specifically what provisions are requested to be waived, a concise statement of the reasons for requesting the waiver, and any conditions proposed to be placed on the waiver, including conditions which would substitute for compliance with the provisions requested to be waived.

401.113(2) *Applicability of rule.* The board may grant a waiver from a rule only if the board has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The board may not waive requirements created or duties imposed by statute.

401.113(3) *Criteria for waiver or variance.* In response to a petition completed pursuant to this rule, the board may, in its sole discretion, issue an order waiving, in whole or in part, the requirements of a rule if the board finds, based on clear and convincing evidence, all of the following:

a. The application of the rule would impose an undue hardship on the person for whom the waiver is requested;

b. The waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;

c. The provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

401.113(4) *Filing of petition.* A petition for a waiver must be submitted in writing to the board as follows:

a. If the petition relates to a pending contested case, the petition shall be filed in the contested case proceeding, using the caption of the contested case.

b. If the petition does not relate to a pending contested case, the petition may be submitted with a caption containing the name of the person for whom the waiver is requested.

c. A petition is deemed filed when it is received in the secretary's office. A petition should be sent to the Board of Trustees, Peace Officers' Retirement, Accident, and Disability System, Attention: Secretary of the Board, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319-0050.

401.113(5) *Content of petition.* A petition for waiver shall include the following information where applicable and known to the requester:

a. The name, address, telephone number, and electronic mail address of the entity or person for whom a waiver is being requested; the case number of or other reference to any related contested case; and the name, address, and telephone number of the petitioner's legal representative, if any.

b. A description of and citation to the specific rule from which a waiver is requested.

c. The specific waiver requested, including the precise scope and duration.

d. The relevant facts that the petitioner believes would justify a waiver under each of the four criteria described in subrule 401.113(3). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition, and a statement of reasons that the petitioner believes will justify a waiver.

e. A history of any prior contacts between the board, other departments or agencies of the state of Iowa, or political subdivisions and the petitioner relating to benefits or potential benefits or eligibility requirements affected by the proposed waiver, including a description of each affected benefit or eligibility requirement held or requested by the requester, any formal charges filed, notices of violation, contested case hearings, or investigations relating to the membership in the system within the last five years.

f. Any information known to the requester regarding the board's action in similar cases.

g. The name, address, and telephone number of any public agency or political subdivision which might be affected by the granting of a waiver.

h. The name, address, and telephone number of any entity or person who would be adversely affected by the granting of a petition. This does not create any duty to individually notify other members of the system, unless they are known to have requested or received a waiver of the identical provisions.

i. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

j. Signed releases of information authorizing persons with knowledge regarding the request to furnish the board with information relevant to the waiver.

401.113(6) *Additional information.* Prior to issuing an order granting or denying a waiver, the board may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the board may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and a representative or representatives of the board related to the waiver request.

401.113(7) *Notice.* The secretary shall acknowledge a petition upon receipt and shall notify the members of the board, the legal counsel to the board and the agency rules administrator of the department of the receipt of the petition as soon as practical after its receipt. The board shall ensure that, within 30 days of the receipt of the petition, notice of the pending petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law, including the petitioner. In addition, the board may give notice to any other person. To accomplish this notice provision, the board may require the petitioner to serve the notice on all persons to whom notice

is required by any provision of law and to provide a written statement to the board attesting that notice has been provided.

401.113(8) *Hearing procedures.* The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case, and shall otherwise apply to board proceedings for a waiver only when the board so provides by order or is required to do so by statute.

401.113(9) *Ruling.* An order granting or denying a waiver shall be in writing and shall contain a reference to the particular person or legal entity and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

a. Board discretion. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the board, upon consideration of all relevant factors. Each petition for a waiver shall be evaluated by the board based on the unique, individual circumstances set out in the petition.

b. Burden of persuasion. The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the board should exercise its discretion to grant a waiver from a rule.

c. Narrowly tailored exception. A waiver, if granted, shall provide the narrowest exception possible to the provisions of a rule.

d. Administrative deadlines. When the rule from which a waiver is sought establishes administrative deadlines, the board shall balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

e. Conditions. The board may place on a waiver any condition that the board finds desirable to protect the public health, safety, and welfare.

f. Time period of waiver. A waiver shall not be permanent unless the petitioner can show that a temporary waiver would be impractical. If a temporary waiver is granted, there is no automatic right to renewal. At the sole discretion of the board, a waiver may be renewed if the board finds that grounds for a waiver continue to exist.

g. Time for ruling. The board shall grant or deny a petition for a waiver as soon as practical but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the board shall grant or deny the petition no later than the time at which the final decision in that contested case is issued.

h. When deemed denied. Failure of the board to grant or deny a petition within the required time period shall be deemed a denial of that petition by the board. However, the board shall remain responsible for issuing an order denying a waiver.

i. Service of order. Within seven days of its issuance, any order issued under this rule shall be transmitted or delivered to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law. A copy of the order shall be provided to the agency rules administrator of the department to facilitate compliance with this rule.

401.113(10) *Indexing.* All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. If petitions or orders may contain information the board is authorized or required to keep confidential, the board may instruct the secretary to accordingly redact confidential information from petitions or orders prior to public inspection.

401.113(11) *Summary reports.* Summary information identifying the rules for which a waiver has been granted or denied, the number of times a waiver was granted or denied for each rule, a citation to the statutory provisions implemented by these rules, and a general summary of the reasons justifying the board's actions on waiver requests shall be included in semiannual reports prepared by the agency rules administrator of the department which contain such information for administrative rules of the department.

401.113(12) *Cancellation of a waiver.* A waiver issued by the board pursuant to this chapter may be withdrawn, canceled, or modified if, after appropriate notice and hearing, the board issues an order finding any of the following:

a. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

b. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or

c. The subject of the waiver order has failed to comply with all conditions contained in the order.

401.113(13) *Violations.* Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this rule who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

401.113(14) *Defense.* After the board issues an order granting a waiver, the order is a defense within its terms and the specific facts indicated therein only for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked.

401.113(15) *Judicial review.* Judicial review of the board's decision to grant or deny a waiver petition may be taken in accordance with Iowa Code chapter 17A.

401.113(16) *Sample petition for waiver.* A petition for waiver filed in accordance with this rule must meet the requirements specified herein and must substantially conform to the following form:

PUBLIC SAFETY PEACE OFFICERS'
RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM

Petition by (name of petitioner) for the waiver/variance of (insert rule citation) relating to (insert the subject matter).	PETITION FOR WAIVER/VARIANCE

1. Provide the name, address, and telephone number of the petitioner (person asking for a waiver or variance). Also provide the name, address, and telephone number of the petitioner's legal representative, if applicable, and a statement indicating the person to whom communications concerning the petition should be directed.

2. Describe and cite the specific rule from which a waiver is requested.

3. Describe the specific waiver requested, including the precise scope and time period for which the waiver will extend.

4. Explain the relevant facts and reasons that the petitioner believes justify a waiver. Include in the answer all of the following:

- Why application of the rule would result in undue hardship to the petitioner;
- Why waiver of the rule would not prejudice the substantial legal rights of any person;
- Whether the provisions of the rule subject to the waiver are specifically mandated by statute or another provision of law; and
- How substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested.

5. Provide a history of any prior contacts between the board, other departments or agencies of the state of Iowa, or political subdivisions and petitioner relating to the benefits or rights affected by the requested waiver. Include a description of each contested case hearing held, or any investigations related to the benefits or rights.

6. Provide information known to the petitioner regarding the board's action in similar cases.

7. Provide the name, address, and telephone number of any public agency or political subdivision that also regulates the activity in question or that might be affected by the granting of the petition.

8. Provide the name, address, and telephone number of any person or entity that would be adversely affected by the granting of the waiver or variance.

9. Provide the name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Provide signed releases of information authorizing persons with knowledge regarding the request to furnish the board with information relevant to the waiver.

I hereby attest to the accuracy and truthfulness of the above information.

(Date) (Petitioner's Signature)

[Editorial change: IAC Supplement 6/17/09]

661—401.114 to **401.200** Reserved.

DECLARATORY ORDERS

661—401.201(17A) Petition for declaratory order. Any person may file with the secretary a petition to the board for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the board. A petition is deemed filed when it is received by that office. The secretary shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the agency an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

PUBLIC SAFETY PEACE OFFICERS'
RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	PETITION FOR DECLARATORY ORDER

The petition must provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by rule 401.207(17A).

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative and a statement indicating the person to whom communications concerning the petition should be directed.

661—401.202(17A) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the department shall give notice of the petition to all persons not served by the petitioner pursuant to rule 401.206(17A) to whom notice is required by any provision of law. The department may also give notice to any other persons.

661—401.203(17A) Intervention.

401.203(1) Any person who qualifies under any applicable provision of law as an intervenor and who files a petition for intervention within 20 days of the filing of a petition for declaratory order (after time

for notice under rule 401.202(17A) and before 30-day time for agency action under rule 401.208(17A)) shall be allowed to intervene in a proceeding for a declaratory order.

401.203(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the department.

401.203(3) A petition for intervention shall be filed with the secretary. Such a petition is deemed filed when it is received by the secretary. The department shall provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

PUBLIC SAFETY PEACE OFFICERS'
RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM

Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition).	PETITION FOR INTERVENTION

The petition for intervention must provide the following information:

1. Facts supporting the intervenor's standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

661—401.204(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The department may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

661—401.205(17A) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the secretary.

661—401.206(17A) Service and filing of petitions and other papers.

401.206(1) *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

401.206(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the secretary. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the secretary.

401.206(3) *Method of service, time of filing, and proof of mailing.* Method of service, time of filing, and proof of mailing shall be as provided by subrule 401.301(7).

661—401.207(17A) Consideration. Upon request by petitioner, the department may schedule a brief and informal meeting between the original petitioner, all intervenors, and the board, a member of the board, or a member of the staff of the department to discuss the questions raised. The board may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the board by any person.

661—401.208(17A) Action on petition.

401.208(1) Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the commissioner of public safety or the commissioner's designee shall take action on the petition as required by Iowa Code section 17A.9(5).

401.208(2) The date of issuance of an order or of a refusal to issue an order is the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

661—401.209(17A) Refusal to issue order.

401.209(1) The board shall not issue a declaratory order where prohibited by Iowa Code section 17A.9, subsection 1, and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

a. The petition does not substantially comply with the required form.

b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the board to issue an order.

c. The board does not have jurisdiction over the questions presented in the petition.

d. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding that may definitively resolve them.

e. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.

f. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.

g. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.

h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge an agency decision already made.

i. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.

j. The petitioner requests the board to determine whether a statute is unconstitutional on its face.

k. The petition relates to any criminal investigation.

l. The petition concerns any procedure or practice of the board or any other agency related to initiation or conduct of criminal investigations or referral of matters for possible criminal investigation or prosecution.

m. The petition states facts and circumstances which are theoretical in nature to the extent that issuance of a declaratory order is unlikely to assist in guiding future conduct or the petitioner is neither a person with interest in the operation of the system nor a representative of such a person. "Representative of such a person" includes any organization with members or participants who are active or retired members of the system, or family members or survivors of active or retired members of the system.

401.209(2) A refusal to issue a declaratory order shall indicate the specific grounds for the refusal, unless the refusal pertains to a matter under criminal investigation, or which has been referred for possible criminal prosecution, in which event no information which might compromise the investigation or prosecution shall be released to the petitioner or any intervenor. A refusal to issue a declaratory order constitutes final agency action on the petition.

401.209(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

661—401.210(17A) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

661—401.211(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to each original petitioner and to each intervenor.

661—401.212(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the board, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the board. The issuance of a declaratory order constitutes final agency action on the petition.

661—401.213 to **401.300** Reserved.

CONTESTED CASES

661—401.301(17A) Contested case proceeding. Consideration of an appeal of a decision of the board shall be a contested case proceeding subject to the provisions of Iowa Code chapter 17A.

401.301(1) *Delivery of notice.* Delivery of the notice of hearing by the secretary constitutes the commencement of a contested case proceeding. Delivery may be executed by regular mail. The notice shall be delivered to the applicant, the applicant's attorney if known, and the assistant attorney general designated to represent the public interest.

401.301(2) *Contents of notice.* The notice of hearing shall contain a statement of the time, place, and nature of the hearing. The notice shall contain a statement that it is the applicant's burden to prove each of the statutory elements relative to the application. The notice shall also contain a reference to the applicable statute and rules.

401.301(3) *Scope of issues.* The applicant shall prove each of the statutory elements required before the application may be granted. Denial of an application shall be upheld based on the applicant's failure to prove any of the statutory elements. When an applicant has requested accidental disability benefits, the board has the option of denying accidental disability benefits, but granting ordinary disability benefits based on the evidence.

401.301(4) *Legal representation.* Following the filing of the notice of hearing, the office of the attorney general shall be responsible for the legal representation of the public interest in all proceedings before the board. The public interest, as referenced in this rule, shall include the responsibility to protect the assets of the system from applications that do not meet the standards set by the statute for disability benefits. Any private party to a contested case shall be entitled to legal representation at the discretion and expense of that party.

401.301(5) *Presiding officer.* The presiding officer in a contested case shall be an administrative law judge assigned by the department of inspections and appeals.

401.301(6) *Procedural matters.* Procedural matters and motions, including, but not limited to, motions to continue, may be heard and ruled upon by the presiding officer.

401.301(7) *Service and filing.*

a. Service—when required. Except where otherwise provided by law, every document filed in a contested case proceeding shall be served upon each of the parties of record to the proceeding, including the assistant attorney general designated as attorney for the state or the agency, simultaneously with their

filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16, subsection 2, the party filing a document is responsible for service on all parties.

b. Service—how made. Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by personal delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

c. Filing—when required. After the notice of hearing, all documents in a contested case proceeding shall be filed with the secretary. All documents that are required to be served upon a party shall be filed simultaneously with the secretary.

d. Filing—when made. Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the secretary at the location set forth in rule 661—400.6(97A), delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

e. Proof of mailing. Proof of mailing includes either:

(1) A legible United States Postal Service postmark on the envelope;
(2) A certified mail return receipt;
(3) A notarized affidavit; or
(4) A certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Secretary of the Board of Trustees, Iowa Department of Public Safety, Peace Officers' Retirement System, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).
>
> (Date) (Signature)

[Editorial change: IAC Supplement 6/17/09]

661—401.302(17A) Discovery.

401.302(1) Pursuant to Iowa Code chapter 17A, discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

401.302(2) Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened by order of the presiding officer. The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

661—401.303(17A) Subpoenas in a contested case. Pursuant to Iowa Code section 17A.13, subsection 1, the board or the presiding officer acting on behalf of the board has the authority to issue subpoenas to compel the attendance of witnesses at depositions or hearings and to compel the production of professional records, books, papers, correspondence and other records which are deemed necessary as evidence in connection with a contested case. A subpoena issued in a contested case under the board's authority may seek evidence whether or not privileged or confidential under law.

401.303(1) The board chair shall, upon the written request of the applicant or the state, issue a subpoena to compel the attendance of witnesses or to obtain evidence which is deemed necessary in connection with a contested case. A command to produce evidence may be joined with a command to appear at deposition or hearing or may be issued separately.

401.303(2) A request for a subpoena shall include the following information, as applicable, unless the subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes:

a. The name, address and telephone number of the person requesting the subpoena;

b. The name and address of the person to whom the subpoena shall be directed;

c. The date, time, and location at which the person shall be commanded to attend and give testimony;

d. Whether the testimony is requested in connection with a deposition or hearing;

e. A description of the books, papers, records or other evidence requested;

f. The date, time and location for production, or inspection and copying.

401.303(3) Each subpoena shall contain, as applicable:

a. The caption of the case;

b. The name, address and telephone number of the person who requested the subpoena;

c. The name and address of the person to whom the subpoena is directed;

d. The date, time, and location at which the person is commanded to appear;

e. Whether the testimony is commanded in connection with a deposition or hearing;

f. A description of the books, papers, records or other evidence the person is commanded to produce;

g. The date, time and location for production, or inspection and copying;

h. The time within which a motion to quash or modify the subpoena must be filed;

i. The signature, address and telephone number of the board administrator or designee;

j. The date of issuance;

k. A return of service attached to the subpoena.

401.303(4) Unless a subpoena is requested to compel testimony or documents for rebuttal or impeachment purposes, the board administrator or designee shall mail copies of all subpoenas to the parties to the contested case. The person who requested the subpoena is responsible for serving the subpoena upon the subject of the subpoena.

401.303(5) Any person who is aggrieved or adversely affected by compliance with the subpoena or any party to the contested case who desires to challenge the subpoena must, within 14 days after service of the subpoena, or before the time specified for compliance if such time is less than 14 days, file with the board a motion to quash or modify the subpoena. The motion shall describe the legal reasons why the subpoena should be quashed or modified, and may be accompanied by legal briefs or factual affidavits.

401.303(6) Upon receipt of a timely motion to quash or modify a subpoena, the board chair shall request an administrative law judge to hold a hearing and issue a decision. Oral argument may be scheduled at the discretion of the board or the administrative law judge. The administrative law judge may quash or modify the subpoena or deny the motion.

401.303(7) A person aggrieved by a ruling of an administrative law judge who desires to challenge that ruling must appeal the ruling to the board by serving on the board's secretary, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge. If the decision of the administrative law judge to quash or modify the subpoena or to deny the motion to quash or modify the subpoena is appealed to the board, the board may uphold or overturn the decision of the administrative law judge.

401.303(8) If the person contesting the subpoena is not the member whose application for benefits is the subject of the contested case, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the member whose application for benefits is the subject of the contested case, the board's decision is not final for purposes of judicial review until there is a final decision in the contested case.

661—401.304(17A) Motions.

401.304(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

401.304(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the board or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

401.304(3) The presiding officer may schedule oral argument on any motion.

401.304(4) Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the board or an order of the presiding officer.

401.304(5) Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served at least 45 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to rule 401.314(17A) and appeal pursuant to subrule 401.312(2).

661—401.305(17A) Settlements. A contested case may be resolved by informal settlement, and settlements are encouraged. Settlement negotiations may be initiated at any stage of a contested case by the assistant attorney general appointed to represent the public interest or by the applicant. The board shall not be involved in negotiation until a written proposed settlement is submitted for approval, unless both parties waive this prohibition.

661—401.306(17A) Prehearing conference.

401.306(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause, the presiding officer may permit variances from this rule.

401.306(2) Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names.

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

401.306(3) In addition to the requirements of subrule 401.306(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters that the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters that will expedite the hearing.

401.306(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

661—401.307(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

401.307(1) A written application for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The presiding officer may waive notice of such requests for a particular case or an entire class of cases.

401.307(2) In determining whether to grant a continuance, the presiding officer may consider:

a. Prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. The existence of an emergency;

e. Any objection;

f. Any applicable time requirements;

g. The existence of a conflict in the schedules of counsel, parties, or witnesses;

h. The timeliness of the request; and

i. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

661—401.308(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing. Unless otherwise provided, a withdrawal shall be with prejudice.

661—401.309(17A) Hearing procedures.

401.309(1) The presiding officer shall have the authority to administer oaths, to admit or exclude testimony or other evidence, and to rule on all motions and objections.

401.309(2) All objections shall be timely made and stated on the record.

401.309(3) Parties have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Any party may be represented by an attorney at the party's own expense.

401.309(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

401.309(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

401.309(6) Witnesses may be sequestered during the hearing.

401.309(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings.

b. The parties shall be given an opportunity to present opening statements.

c. The parties shall present their cases in the sequence determined by the presiding officer.

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law.

e. When all parties and witnesses have been heard, the parties may be given the opportunity to present final arguments.

f. The presiding officer may enter a default judgment against a party who fails to appear at the hearing.

401.309(8) The presiding officer has the right to question a witness. Examination of witnesses by the presiding officer is subject to properly raised objections.

401.309(9) The hearing shall be open to the public, except as otherwise provided by law.

401.309(10) Oral proceedings shall be electronically recorded. Upon request, the board shall provide a copy of the whole or any portion of the audio recording at a reasonable cost. A certified shorthand reporter may be engaged to record the proceeding at the request of a party and at the expense of the party making the request. A transcription of the record of the hearing shall be made at the request of either party at the expense of the party making the request. The parties may agree to divide the cost of the transcription. A record of the proceedings, which may be either the original recording, a copy, or a transcript, shall be retained by the secretary for five years after the resolution of the case.

401.309(11) Default.

a. If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

b. Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

c. Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final board action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by subrule 401.312(2). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

d. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

e. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

f. "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

g. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding.

h. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

i. A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues (but, unless the defaulting party has appeared, it cannot exceed the relief demanded).

661—401.310(17A) Evidence.

401.310(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

401.310(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

401.310(3) Evidence in the proceeding shall be confined to the contested issues as provided in Iowa Code section 97A.6.

401.310(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

401.310(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

401.310(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

661—401.311(17A) Ex parte communication.

401.311(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. Nothing in this rule is intended to preclude board members from communicating with other board members or members of the board staff, including the secretary, other than those with a personal interest in, or those engaged in personally investigating, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties, as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

401.311(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending before the board.

401.311(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

401.311(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

401.311(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

401.311(6) The secretary may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as the secretary is not disqualified from participating.

401.311(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

401.311(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified.

a. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order; or

b. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited

communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

401.311(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment, unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13, subsection 2, or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

401.311(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule. Violation of ex parte communication prohibitions by staff shall be reported to the board and to the director of the administrative services division of the department.

661—401.312(17A) Decisions.

401.312(1) *Proposed decision.* The decision prepared by the presiding officer is a proposed decision. The proposed decision becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in subrule 401.312(2).

401.312(2) *Appeals and review.*

a. Appeal by party. Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

b. Review. The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

c. Notice of appeal. An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

(1) The parties initiating the appeal;

(2) The proposed decision or order appealed from;

(3) The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

(4) The relief sought;

(5) The grounds for relief.

d. Requests to present additional evidence. A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

e. Scheduling. The board shall issue a schedule for consideration of the appeal.

f. Briefs and arguments. Unless otherwise ordered, briefs, if any, must be filed within five days of meeting.

661—401.313(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

661—401.314(17A) Applications for rehearing.

401.314(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

401.314(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought.

401.314(3) *Time of filing.* The application shall be filed with the board within 20 days after issuance of the final decision.

401.314(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein.

401.314(5) *Disposition.* The board may meet telephonically to consider an application for rehearing. Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

These rules are intended to implement Iowa Code chapters 17A and 97A.

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CHAPTER 402
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—ELIGIBILITY, BENEFITS, AND PAYMENTS

[Prior to 10/27/04, see 581—Ch 24]

661—402.1 to **402.99** Reserved.

DIVISION I
ELIGIBILITY

661—402.100(97A) Age of qualification. The age of qualification for benefits under Iowa Code Supplement chapter 97A shall mean the age on the member's last birthday.

661—402.101(97A) Date of retirement. Date of retirement shall mean the first day on retirement and not the last day on duty.

661—402.102(97A) Application of Iowa Code Supplement section 97A.6, subsection 12. Iowa Code Supplement section 97A.6, subsection 12, applies to the deceased member's spouse and children only if the spouse was married to the deceased member at or before the time of retirement and the children are the natural children of the deceased member or were legally adopted at or before the time of retirement of the member. If there is no surviving spouse of a marriage solemnized prior to retirement of a deceased member, then "surviving spouse" means a surviving spouse of a marriage of two years or more solemnized subsequent to the retirement of the member.

661—402.103(97A) Date of death. In the event of the death of a member, the date of death will be considered to be the member's last day on the payroll for earned compensation or on pension, and the next day following will be the first day for the spouse's and children's benefits. The start of benefits shall not be delayed by the payout of any other compensation.

661—402.104(97A) Age of spouse. When the spouse of a deceased active member is to receive an annuity payment from the member's contributions, the age of the spouse at the spouse's nearest birthday shall govern. The computation shall be the spouse's birth date subtracted from the first date that spouse's benefits begin to accrue.

661—402.105 to **402.199** Reserved.

DIVISION II
BENEFITS AND PAYMENTS

661—402.200(97A) Computation of average final compensation. Computation of the average final compensation shall be made using the earnable compensation of the member during the three years of the member's service as a member of the department during which the member received the highest amount of compensation. Overtime compensation, if any, and periods without pay shall not be considered in this computation.

EXCEPTION: If a member retires before attaining three years of service, the average final compensation shall be the total of the earnable compensation from the date the member was sworn into service divided by the number of months of service and multiplied by 12.

661—402.201(97A) Workers' compensation—effect on benefit payment. If workers' compensation benefits are payable because of a member's disability or death, the retirement or death benefit payable, other than a line-of-duty death benefit paid pursuant to 661—Chapter 403, from the system shall be reduced by the actuarial equivalent of the total workers' compensation.

402.201(1) Monthly peace officers' retirement system benefits shall be reduced by the monthly benefit received from workers' compensation.

402.201(2) Peace officers' retirement system benefits shall be reduced in the amount of permanent partial disability benefits paid by workers' compensation. Benefits will be withheld in the amount of permanent partial disability benefits.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.202(97A) Errors in payments. If an error in payments already made to a member or beneficiary is discovered, arrangements shall be made to correct the error, either through recovery of overpayments from the member or beneficiary or through additional compensation paid to the member or beneficiary to adjust for underpayments. Schedules referenced in this rule shall commence only after presentation to and approval by the board of trustees.

402.202(1) As soon as practical after being discovered, underpayments shall be corrected through a lump-sum payment to the member or beneficiary in an amount equal to the total amount of underpayments to date and an amount of interest such that the total lump-sum payment is actuarially equivalent to the total amount of underpayments. The member or beneficiary may request a method of repayment other than a lump-sum payment, in which case a repayment schedule may be mutually agreed upon between the board and the member or beneficiary.

402.202(2) Overpayments other than those which resulted from fraudulent acts on the part of the member or beneficiary receiving the payments shall be recovered from the member or beneficiary. The preferred method of recovery, if the member or beneficiary is continuing to receive payments from the system, shall be withholding monthly an amount equivalent to the monthly average of the amount of overpayments during the period in which the overpayments were made, until total repayments equal a sum actuarially equivalent to the total amount of overpayment. If the member or beneficiary is not receiving payments from the system, the board may seek repayment in a lump sum including the amount of overpayments and interest in an amount such that the total repayment is actuarially equivalent to the total amount of overpayments, although the member or beneficiary may request a repayment schedule be established and the board may agree to do so.

402.202(3) An overpayment which resulted in whole or in part from a fraudulent act or acts on the part of the member or beneficiary receiving the payments shall be repaid to the system in an amount which is actuarially equivalent to the amount of the overpayment plus a reasonable assessment of the administrative costs to the system and the department to recover the overpayment. The preferred method of repayment is a lump-sum payment collected as soon as practical after the overpayment and the fraudulent act are discovered, although the board shall accept a repayment schedule established by a court which orders restitution in relation to a conviction stemming from the fraudulent act or acts. The board may agree to an alternative payment schedule at the request of the member or beneficiary if there is no applicable order of restitution.

The board may find, on the basis of clear and convincing evidence, that an overpayment resulted from a fraudulent act or acts on the part of a member or beneficiary. A conviction based upon a fraudulent act or acts committed in relation to the receipt of benefits from the system shall be prima facie evidence of fraud for purposes of this subrule.

661—402.203(97A) Initial benefit for a child. Initial benefit for a child as specified in Iowa Code Supplement section 97A.6, subsection 8, 9 or 12, shall be 6 percent of the monthly earnable compensation payable to an active member having the rank of senior trooper of the Iowa state patrol. A senior trooper, for the purposes of Iowa Code Supplement chapter 97A, is a peace officer having at least ten years of active service with the Iowa state patrol.

661—402.204(97A) Computation for partial month. Computation of retirement benefits for a partial month shall be based on the actual number of days in the month, i.e., monthly benefits divided by the number of days in the month multiplied by the number of days due.

661—402.205(97A) One year of service. For the purpose of computing service, service for fewer than six months of a year is not creditable as service. Service of six months or more in any year shall be

equivalent to one year of service; however, in no case shall a member receive more than one year of service credit for each 12-month period of service.

661—402.206(97A) Termination prior to retirement.

402.206(1) Members who terminate covered employment prior to age 55 other than by death or disability have certain rights to their accumulated contributions.

a. A member with fewer than four years of service is not entitled to benefits under the system. A member terminating employment with less than four years of service has the following options for the handling of the member's contributions to the system:

(1) The member may withdraw the member's contributions along with accumulated interest.

(2) The member may have all or a part of the member's qualifying contributions along with accumulated interest rolled forward to a qualified retirement plan and may withdraw the balance of the member's contributions.

(3) The member may leave the member's contributions in the system as long as the member continues to be a member of the system. A member ceases to be a member of the system should the member in any period of five consecutive years after last becoming a member be absent from service for more than four years. Should a member cease to be a member, the member's contributions shall be paid to the member as provided in this paragraph.

b. A member with four or more years of service is a "vested member" and is entitled to benefits under the system. The member's options under the system are as follows:

(1) Upon attaining retirement age, the member may receive a service retirement allowance of four twenty-seconds of the retirement allowance the member would receive at retirement if the member's employment had not been terminated, and an additional one twenty-second of such retirement allowance for each additional year of service not exceeding 22 years of service. Should the member have over 22 years of service, upon the member's retirement there shall be added 2¾ percent of the member's average final compensation for each year over 22 years for up to 10 additional years of service. The amount of the retirement allowance shall be calculated in the manner provided in this subparagraph using the average final compensation at the time of termination of the member's employment.

(2) The member may withdraw the member's contributions pursuant to Iowa Code section 97A.16, along with accumulated interest.

(3) The member may have all or a part of the member's qualifying contributions along with accumulated interest rolled forward to a qualified retirement plan and may withdraw the balance of the member's contributions.

402.206(2) The interest rate shall be the composite rate of return for the fiscal year as reflected in the investment performance analysis, provided by the investment consultants for the system, as specified in the report for the quarter ending June 30 of the fiscal year, adjusted by the administrative expense of the system for the fiscal year. The administrative expense rate shall be calculated by dividing the actual administrative expense for the fiscal year by the fund balance on June 30 of the fiscal year.

402.206(3) Interest shall be credited to the member's account annually as of June 30. The interest credited to the member shall be calculated by multiplying the annual interest rate by the member's average balance for the fiscal year, with interest credited for each full month of membership.

402.206(4) Members withdrawing contributions under this rule shall submit a written request to the secretary.

661—402.207(97A) Optional retirement benefits. Members of the system who retire under a service retirement may elect to receive one of the following optional retirement benefits and have the optional retirement benefit or a designated fraction of the benefit paid to the member's beneficiary:

1. Straight life annuity.
2. Straight life annuity with five years certain.
3. Straight life annuity with ten years certain.
4. Joint and 50 percent survivor annuity.
5. Joint and 75 percent survivor annuity.

6. Joint and 100 percent survivor annuity.
7. Single life annuity with a designated lump sum.

For the purposes of this rule, a "beneficiary" means a member's spouse, child, or dependent parent.

661—402.208(97A) Options not reversible once payments begin—exceptions.

402.208(1) The member may change or cancel the member's selected optional benefit until the first monthly benefit payment is made using the selected option. After the first monthly payment to the member or beneficiary, the option shall become permanent and not subject to cancellation or change.

402.208(2) If a member dies without designating a beneficiary prior to receipt in benefits of an amount equal to the total amount in the member's credit at the time of separation from service, the election is void.

402.208(3) If a member who has designated a beneficiary dies and the beneficiary subsequently dies prior to receipt in benefits of an amount equal to the total amount in the member's credit at the time of separation from service, the election remains valid.

661—402.209(97A) Method of calculating annual adjustments when optional retirement benefits are selected. Whenever an optional benefit as provided for in rule 661—402.207(97A) has been selected by a member, the annual adjustments provided for in Iowa Code Supplement section 97A.6, subsection 14, shall continue to be provided.

661—402.210(97A) Termination of benefits when optional retirement benefits are selected. Whenever an optional benefit as provided for in rule 661—402.207(97A) has been selected by a member, benefit payments shall terminate as follows, except as provided in rule 661—402.208(97A):

1. Straight life annuity. Upon the death of the retired member, all future retirement payments shall cease.
2. Straight life annuity with five years certain. Upon the death of the retired member, or five years from the member's original retirement date, whichever is later, all future retirement payments shall cease.
3. Straight life annuity with ten years certain. Upon the death of the retired member, or ten years from the member's original retirement date, whichever is later, all future retirement payments shall cease.
4. Joint and 50 percent survivor annuity. Upon the death of the retired member, the surviving beneficiary shall have the beneficiary's annual annuity established at 50 percent of the member's amount. Upon the death of both the member and the beneficiary, all future retirement payments shall cease.
5. Joint and 75 percent survivor annuity. Upon the death of the retired member, the surviving beneficiary shall have the beneficiary's annual annuity established at 75 percent of the member's amount. Upon the death of both the member and the beneficiary, all future retirement payments shall cease.
6. Joint and 100 percent survivor annuity. Upon the death of the retired member, the surviving beneficiary shall have the annual annuity continue at the member's amount. Upon the death of both the member and the beneficiary, all future retirement payments shall cease.
7. Single life annuity with a designated lump sum. Upon the death of the retired member, the beneficiary shall receive the single lump-sum payment, and all future retirement payments shall cease.

661—402.211(97A) Impact of optional benefit selections on child benefits. The selection of an optional retirement benefit by a member shall not change the benefit that a child of a deceased member would otherwise be eligible to receive.

661—402.212(97A) Method of calculating annual adjustment for members who retire on or after July 1, 2010. For members retiring on or after July 1, 2010, there shall be an adjustment occurring on July 1 for which the following applicable amount shall be added to the member's monthly allowance:

402.212(1) On the first July 1 following the retirement of a member, there shall be added to the monthly allowance the amount of $15. There shall be no other adjustment to the monthly allowance under the provisions of this rule until the adjustment provided in subrule 402.212(2) applies.

402.212(2) An additional $5 shall be added to the member's monthly allowance when the member's retirement date was at least five years, but less than ten years, prior to the effective date of the

adjustment, the total adjustment to the member's monthly allowance then being $20. There shall be no other adjustment to the monthly allowance under the provisions of this rule until the adjustment provided in subrule 402.212(3) applies.

402.212(3) An additional $5 shall be added to the member's monthly allowance when the member's retirement date was at least 10 years, but less than 15 years, prior to the effective date of the adjustment, the total adjustment to the member's monthly allowance then being $25. There shall be no other adjustment to the monthly allowance under the provisions of this rule until the adjustment provided in subrule 402.212(4) applies.

402.212(4) An additional $5 shall be added to the member's monthly allowance when the member's retirement date was at least 15 years, but less than 20 years, prior to the effective date of the adjustment, the total adjustment to the member's monthly allowance then being $30. There shall be no other adjustment to the monthly allowance under the provisions of this rule until the adjustment provided in subrule 402.212(5) applies.

402.212(5) An additional $5 shall be added to the member's monthly allowance when the member's retirement date was at least 20 years prior to the effective date of the adjustment, the total adjustment to the member's monthly allowance then being $35.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.213(97A) Method of calculating annual adjustment for members who retired prior to July 1, 2010. For members having retired before July 1, 2010, there shall be an adjustment occurring on July 1 for which the following applicable amount shall be added to the member's monthly allowance:

402.213(1) For members having retired on or after July 2, 2009, but before July 1, 2010, there shall be added to the monthly pension allowance the amount of $15. There shall be no other adjustment to the monthly allowance under the provisions of this rule until the adjustment provided in subrule 402.212(2) applies.

402.213(2) For members having retired on or after July 2, 2008, but before July 2, 2009, no adjustment to the monthly allowance shall be made until the adjustment provided in subrule 402.212(2) applies.

402.213(3) For members having retired on or after July 2, 2007, but before July 2, 2008, no adjustment to the monthly allowance shall be made until the adjustment provided in subrule 402.212(5) applies.

402.213(4) For those members having retired on or before July 1, 2007, thus having received more than a total of $35 added to the monthly allowance, there shall be no additional adjustments made to monthly allowances. Adjustments having resulted in more than $35 added to the monthly allowance prior to July 1, 2010, shall not be considered overpayments, and the monthly allowances of members so affected shall not be reduced, nor shall members be required to repay any amount to the system.

NOTE: The following table summarizes the adjustments provided for in this rule.

Retirement Date	July 1 Monthly Allowance Adjustment	Adjustment Date
July 2, 2009 – June 30, 2010	$15.00	July 1, 2010
July 2, 2008 – July 1, 2009	$5.00	July 1, 2013
July 2, 2007 – July 1, 2008	$5.00	July 1, 2028
Retired before July 2, 2007	$0.00	Not applicable

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661—402.214(97A) Determination of survivor's pension. For the purposes of determining a survivor's pension, the adjustments to monthly allowance provided in rules 661—402.212(97A) and 661—402.213(97A) shall be reduced in the same manner as is provided for the member's optional retirement benefit election made under rule 661—402.207(97A) or as provided in Iowa Code section 97A.6(12).

NOTE: Section 17 of 2010 Iowa Acts, House File 2518, reads as follows:

Sec. 17. PUBLIC SAFETY PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—ADJUSTMENT OF PENSIONS PAYABLE. It is the intent of the general assembly that the applicable amount for each adjustment occurring on July 1 as provided in section 97A.6, subsection 14, paragraph "a", subparagraph (2), subparagraph division (a), shall be the exact dollar amount listed in each subparagraph subdivision of subparagraph division (a) for each July 1 in which that particular subparagraph subdivision applies and shall not be increased above the amount listed in that subparagraph subdivision for each year that the subparagraph subdivision applies. However, the applicable amount for each adjustment occurring on or after July 1, 2010, as provided by this section, shall not be less than the applicable amount for the adjustment for the previous July 1.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.215 to **402.299** Reserved.

DIVISION III
SERVICE PURCHASES

661—402.300(97A) Purchase of eligible service credit. Effective July 1, 2010, and no later than July 1, 2011, an active member may make application to the system to purchase up to the maximum amount of permissive service credit for eligible qualified service.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.301(97A) Determination of eligible service.

402.301(1) *Eligible qualified service.* "Eligible qualified service" means service as a member of a city fire retirement system or police retirement system operating under Iowa Code chapter 411 prior to January 1, 1992, for which service has not previously been credited. Eligible qualified service does not include service if the receipt of credit for such service would result in the member's receiving a retirement benefit under more than one retirement plan for the same period of service.

402.301(2) *Permissive service credit.*

a. Permissive service credit is credit that will be recognized by the system for purposes of calculating a member's benefit, for which the member did not previously receive service credit in the system, and for which the member voluntarily contributes to the system the amount required by the system, not in excess of the amount necessary to fund the benefit attributable to such service.

b. Permissive service credit shall be calculated in years at the rate of one year of service for six months or more of a year actually worked with no more than one year of service to be credited for all service in one calendar year.

c. An active member may make contributions to the system to purchase up to the maximum amount of permissive service credit for eligible qualified service as determined by the system, pursuant to Internal Revenue Code Section 415(n).
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.302(97A) Determination of cost to member.

402.302(1) *Determination of service credit.* A member may determine the amount of permissive service credit, which shall be documented on a form provided by the secretary. Such documentation shall include the notarized certification by an official of the city or agency that employed the member and shall include periods of service and member retirement contributions to the former system during the indicated time of service. In the event member contribution information is not available from the employing city or agency, documentation may be provided in another form acceptable to the board. Acceptable documentation may include, but is not limited to, IRS form W-2, Social Security earnings statements, pay stubs or Iowa tax form 1040 or 1040A.

402.302(2) *Actuarial cost quote of permissive service credit.*

a. A member may submit certification of service credit to the secretary to obtain a cost quote of permissive service.

b. The secretary shall review and verify the submitted certification of service credit to ensure that the requirements of subrule 402.302(1) have been met.

c. When service credit has been verified, the secretary shall submit a request to the actuary contracted by the system to determine the cost to purchase permissive service credit.

d. A member may request cost quotes to purchase permissive service credit for a maximum of two time periods at no cost to the member.

e. If a member requests a third or subsequent cost quote, the member shall be required to pay for the cost of the quote.

f. A second or subsequent cost quote for the same period of permissive service credit shall replace all previous cost quotes for that time period.

g. If the requirements of subrule 402.302(1) cannot be verified, the request for a cost quote shall not be submitted to the actuary but rather shall be referred to the board for review at the next regularly scheduled meeting.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.303(97A) Application process.

402.303(1) *Actuarial cost quote of permissive service credit.* When made available to the secretary by the actuary, the cost quote shall be forwarded to the member promptly. Such delivery may be made through electronic mail, facsimile transmission, regular mail, or personal service. The cost quote of permissive service credit shall remain valid for six months from the date of the cost quote unless replaced by a subsequent cost quote for the same time period of permissive service credit.

402.303(2) *Submission of application to purchase permissive service credit.* The member may submit to the secretary an application to purchase years of permissive service credit in an amount no greater than the maximum certified years of permissive service credit at a rate quoted by the actuary less an amount equal to the member's contributions pursuant to Iowa Code chapter 411 for the period of eligible qualified service together with interest at a rate determined by the board. Full payment in the form of a check or money order payable to the Peace Officers' Retirement, Accident, and Disability System, or certification of intent to pay through a qualified plan, or a combination thereof, shall accompany the application to purchase permissive service credit. Contributions shall be made by the member within the six-month period the quote is valid.

402.303(3) *Acceptance of application to purchase permissive service credit.* If the application is accepted, the secretary shall deposit the full payment into the system's account and shall adjust the member's years of service and contributions to reflect the purchase of service. Prior to the receipt of full payment, the secretary shall make no adjustment to the member's years of service or contributions.

402.303(4) *Rejection of application to purchase permissive service credit.* If the application is rejected, the secretary shall refer the rejected application to the board for review at the next regularly scheduled meeting.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.304(97A) Service adjustment irrevocable. An adjustment of a member's years of service which has been completed pursuant to subrule 402.303(3) is irrevocable. However, this rule shall not be interpreted to limit the system's ability to refund service credit purchase amounts when required in order to meet the provisions of the Internal Revenue Code.

[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.305(97A) Board review.

402.305(1) *Review of rejection of certification of service credit.* The board shall review a rejected certification of service credit. If the board overrules the rejection, the secretary shall submit the certification of service credit to the actuary to determine the member's cost to purchase permissive service credit. If the board sustains the rejection, the member may appeal the action pursuant to 661—subrule 401.2(2).

402.305(2) *Review of rejection of application to purchase service credit.* The board shall review any application to purchase service credit which has been rejected. If the board overrules the action, the secretary shall process the application pursuant to subrule 402.303(3). If the board sustains the rejection,

the secretary shall return the payment to the member. The member may appeal the action pursuant to 661—subrule 401.2(2).
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.306(97A) Other provisions.

402.306(1) Within 60 days following the entry of an adjustment to a member's years of service based on a purchase of permissive service credit, the secretary shall report the purchase to the system under which the service credit was originally earned.

NOTE: This notification is intended to meet the requirement that a member not receive a retirement benefit under more than one retirement plan for the same period of service.

402.306(2) The average final compensation of the member shall not be affected by the purchase of permissive service credit.
[**ARC 8935B**, IAB 7/14/10, effective 7/1/10]

661—402.307(97A) Purchase of service credit for military service.

402.307(1) *Eligibility.* Effective July 1, 2010, an active member of the system who has been a member of the retirement system five or more years may purchase service credit for military service under this chapter.

NOTE: Determination of length of active membership will be made pursuant to Iowa Code section 97A.3.

402.307(2) *Service eligible for purchase.* An eligible member may elect to purchase up to five years of service for military service that is not already recognized by the system or required to be recognized by the system under Internal Revenue Code Section 414(u) or the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

a. Permissive service credit shall be calculated in years at the rate of one year of service for six months or more of a year actually worked with no more than one year of service to be credited for all service in one calendar year.

b. A member may elect to purchase service credit for all or part of the member's eligible service up to the five-year limitation and limitations of Internal Revenue Code Section 415(n).

c. For purposes of this rule, "military service" means active duty service in any of the following:

(1) The United States Army, Navy, Marine Corps, Air Force or Coast Guard;

(2) The United States Army Reserves, Naval Reserves, Marine Corps Reserves, Air Force Reserves or Coast Guard Reserves;

(3) The Army National Guard or Air National Guard;

(4) The Commissioned Corps of the Public Health Service; or

(5) Any other category of persons designated by the President in a time of war or emergency.

402.307(3) *Application.* A member seeking to purchase service credit under this rule shall file a written application with the system requesting an actuarial determination of the purchase cost of the requested service credit. Applications shall be on forms provided by the secretary. The member shall include with the application:

a. Periods of military service for which credit is requested.

b. Proof of applicable military service. Records that may be acceptable for this purpose include the member's DD Form 214, discharge papers or other records as determined by the system.

c. Any other documentation reasonably requested by the system.

402.307(4) *Determination of cost to member.* Upon receipt of the written application and supporting documentation, the secretary shall review and verify the submitted documents. The secretary shall submit the application and pertinent member information to the actuary contracted by the system to determine the cost to purchase the military service. The cost of actuarial determinations shall be borne by the member, payable upon receipt of the cost quote.

402.307(5) *Application process.*

a. Actuarial cost quote of military service credit. When made available to the secretary by the actuary, the cost quote shall be forwarded to the member promptly. Such delivery may be made through electronic mail, facsimile transmission, regular mail, or personal service. The cost quote for purchase

of credit for military service shall remain valid for six months from the date of the cost quote unless replaced by a subsequent cost quote for the same time period of military service.

b. Submission of application to purchase military service credit. The member may submit to the secretary an application to purchase years of military credit in a cumulative amount no greater than five years. Full payment in the form of a check or money order payable to the Peace Officers' Retirement, Accident, and Disability System, or certification of intent to pay through a qualified plan, or a combination thereof, shall accompany the application to purchase military service credit.

c. Acceptance of application to purchase military service credit. If the application is accepted, the secretary shall deposit the full payment in the system's account and shall adjust the member's years of service and contributions to reflect the purchase of credit for military service. Prior to the receipt of full payment, the secretary shall make no adjustment to the member's years of service or contributions.

402.307(6) *Revocation.* A member may revoke a service purchase election and receive a refund without interest of the purchase cost paid, provided that the revocation request is in writing and is received by the system no later than 60 days following the date of the receipt of the payment of the purchase cost by the system and prior to the date of the commencement of benefits to the member under Iowa Code section 97A.6.

402.307(7) *Refund when required by Internal Revenue Code.* This rule shall not be construed to limit the system's ability to refund service credit purchase amounts when required in order to meet the provisions of the Internal Revenue Code.

402.307(8) *Rejection of application to purchase military service credit.* If the application is rejected, the secretary shall refer the rejected application to the board for review at the next regularly scheduled meeting.

402.307(9) *Board review.* The board shall review any rejected application for purchase of military service credit. If the board overrules the action, the secretary shall process the application. If the board sustains the rejection, the secretary shall return the payment to the member. The member may appeal the action pursuant to 661—subrule 401.2(2).

402.307(10) *Average final compensation.* The average final compensation of the member shall not be affected by the purchase of credit for military service.

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CHAPTER 404
PEACE OFFICERS' RETIREMENT, ACCIDENT, AND DISABILITY SYSTEM—TEMPORARY INCAPACITY
Rescinded IAB 7/14/10, effective 7/1/10

CHAPTERS 405 to 499
Reserved